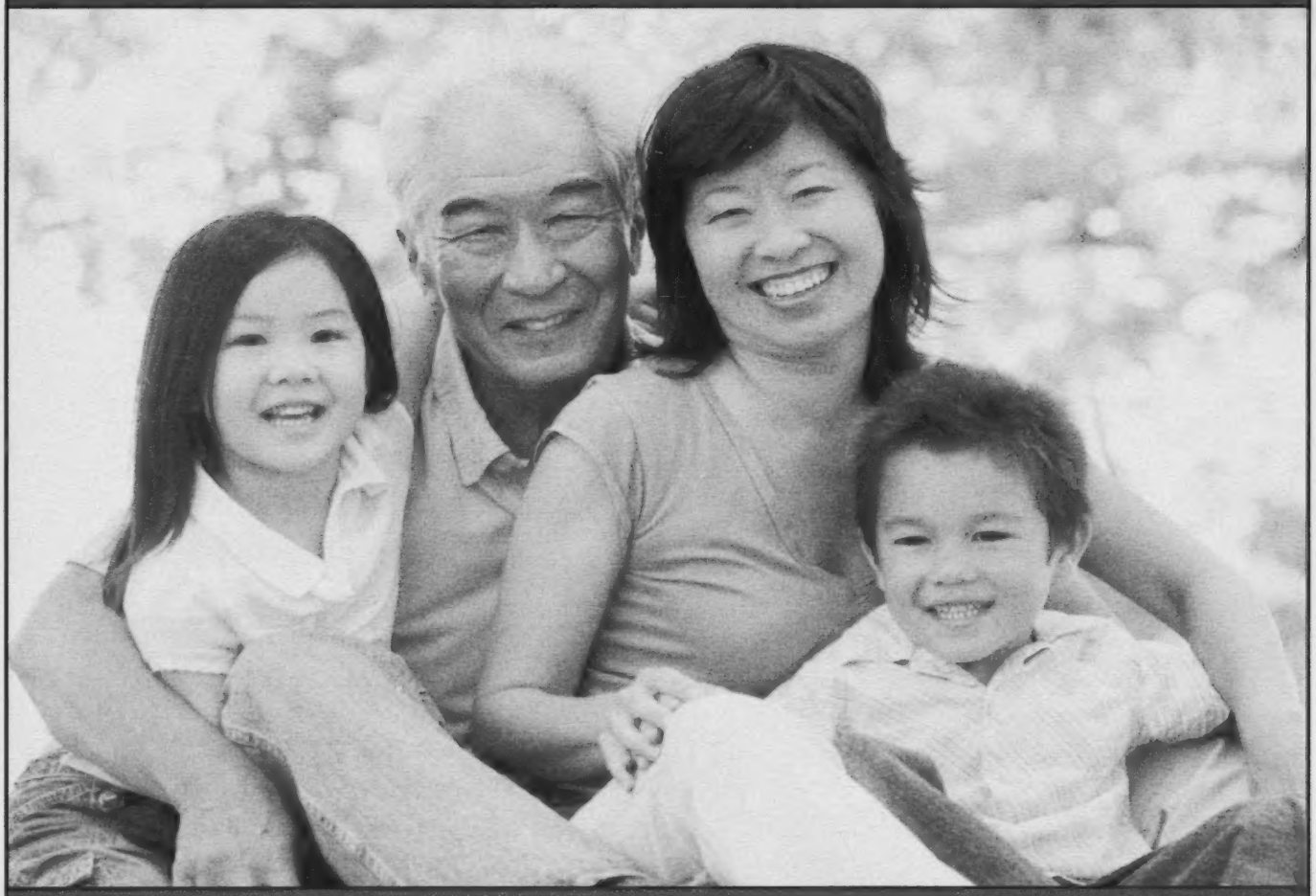
Hamilton Niagara Haldimand Brant **LHIN**



Dramatically Improving the Patient Experience through Quality, Integration and Value

2014-2015 Annual Report

Ontario
Local Health Integration Network

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Hamilton Niagara Haldimand Brant Local Health Integration Network

Vision, Mandate, Mission and Values

Vision

A health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren.

Mandate

To plan, fund and integrate the local health system to provide appropriate, coordinated, effective and efficient health services in Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk.

Mission

To ensure availability of, and access to, linked services in order to improve the health of the population and the continuity of health care.

Values

Respect; Integrity; Accountability

We work from the approach of being a catalyst for change; with a viewpoint based on the individual, and their caregivers, who need access to local health services.

To achieve this we are committed to:
Transparency; Collaboration; Innovation; Real Conversation

Message from the CEO and Chair

In our Annual Report – twelve months ago – we reconfirmed our commitment to the people of HNHB LHIN to continue to dramatically improve the patient experience through quality, integration and value.

We openly acknowledged that the current health care system needed to work better for citizens and be better positioned to care for citizens. We knew then that we must turn the health care system on its head and shift the focus from providers to the **person.** We hope, as you read our 2014-2015 Annual Report, you'll agree that the past year saw a demonstrable step in that direction.

Our new Minister of Health and Long-Term Care Dr. Eric Hoskins took the health helm in June, 2014 and by September the first Minister's Mandate letter clearly focused on patients – **Putting Patients at the Centre — the Right Care, Right Place, Right Time**. **The Minister's** Patients First: Action Plan for Health Care, released in February, 2015, was the next phase changing and improving Ontario's health system. It exemplifies the commitment to put people and patients at the centre of the system by focusing on putting patients' needs first.

The Minister's Action Plan aligned very well with our own five- year Strategic Health System Plan (SHSP) which has guided our work since 2012. The SHSP has ensured our gaze was, and continues to be, firmly focused on our strategic aim and strategic directions.

Strategic Aim
Dramatically improving the patient experience through Quality, Integration and Value.

Strategic Directions

1. Dramatically improving the patient experience by embedding a culture of quality throughout the system.
2. Dramatically improving the patient experience by integrating service delivery.
3. Dramatically improving the patient experience by evolving the role of the LHINs to become health system commissioners.

Our work continues and we continue to make significant steps in the right direction. This Annual Report is an opportunity to bring a year's worth of work together in one place – to share with our community the work that has been accomplished and the work still underway. Here are just a few of the highlights you'll read more about in the pages ahead:

- **Quality** is paramount as the LHIN executes its Strategic Health System Plan. We are focused on a number of initiatives including the Quality Guidance Council, development of a LHIN-wide Quality Plan and the addition of a quality obligation within the Service Accountability Agreements.
- A consistent approach to **LHIN-wide integrated clinical programs** incorporating clear expectations, strong physician engagement and leadership, and strong administrative and organizational leadership achieved great success with measurable outcomes - Integrated Cancer Services Plan, Integrated Vascular Clinical Services Plan and Thoracic Clinical Services Plan.
- Strides are being seen in **Mental Health and Addictions** with the local success and expansion of the Mobile Crisis Rapid Response Team (MCRRT) in Hamilton and soon to be in Brantford. St. Joseph's Healthcare Hamilton and Hamilton Police collaborated on a successful 16-month pilot project - the first-of-its kind in Canada. The MCRRT is meeting its objective of reducing the number of individuals

being taken to hospital as well as reducing the number of hour's uniform patrol officers are spending at hospital.

- The **Behavioural Supports Ontario** strategy continued its focus on improving care and system navigation for individuals/caregivers who have, or are at risk of responsive behaviours. Collaboration among health service providers enabled radical change driven by a value statement which represents the voice of the individual with responsive behaviours.
- **Hospice Palliative Care**, also referred to as "palliative care," is a philosophy of care that aims to relieve suffering and improve the quality of living and dying for people. The LHIN's Hospice Palliative Care (HPC) Regional Program Council continues to work to ensure appropriate HPC services are provided in hospitals, residential hospices, long-term care homes and in a person's home when they are needed.

We sincerely thank and appreciate all of our health care partners for their dedication to improving the health care experience for the citizens of our communities. We know we're doing this work together – we rely heavily on partners across our communities to improve the delivery of health care for our citizens. It's their hard work and determination that demonstrates what is possible when the LHIN, health service providers, citizens and stakeholders **work together with a common vision.**

Our journey together is not over. The work we are doing continues. We must continue to create a health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren. The work we are doing is dramatically improving the patient experience - thank you for keeping our patients and their families at the centre of your thinking and your work.

Sincerely,

Donna Cripps
Chief Executive Officer

Michael Shea
Board Chair

The HNHB LHIN Board of Directors

From left to right: Michael Shea, Laurie Ryan-Hill, Mervin Witter , Ruby Jacobs and Helen Mulligan.

Michael Shea, Chair

Appointed: October 28, 2010 • Term: 3 years
Appointed Chair: June 2, 2011 • Term: 3 years
Re-appointed: October 27, 2013 • Term: 3 years

*Ruby Jacobs, Vice Chair

Appointed: March 3, 2010 • Term: 3 years
Re-appointed: March 20, 2013 • Term: 3 years
*Appointed to Vice Chair effective December 1, 2014

Helen Mulligan, Member

Appointed: June 17, 2010 • Term: 3 years
Re-appointed: June 17, 2013 • Term: 3 years

Laurie Ryan-Hill, Member

Appointed: May 17, 2011 • Term: 3 years
Re-appointed: May 17, 2014 • Term: 3 years
*Appointed to Audit Chair effective December 1, 2014

Mervin Witter, Member

Appointed: June 2, 2011 • Term: 3 years
Re-appointed: June 2, 2014 • Term: 3 years

Transitions in Board Membership

Having completed the allowable two three-year terms on the Board of Directors Bob Lawler completed his tenure November 30 2014. Bob was a valued member of the Board who also served as Audit Chair and Vice Chair. With Bob's departure, and effectiveDecember 1, 2014, Ruby Jacobs became Vice Chair and Laurie Ryan-Hill became Audit Chair.

Relationship Between the Board and Leadership Team

As of March 31, 2015, the HNHB LHIN Leadership Team included the CEO and Directors of Communications, Community Engagement and Corporate Services, Health System Transformation, Access to Care, Quality and Risk Management, Finance, Health Links and Strategic Initiatives, and Physician Lead, Clinical Health System Transformation.

Leadership Team members attend the regular Board business meetings, including the Audit, and Quality and Safety Committees, as well as Board education meetings, and present monthly verbal and written reports to the Board on the activities in their respective portfolios.

Led by the CEO, and guided by the Integrated Health Service Plan (IHSP), Annual Business Plan (ABP), the Leadership Team guides strategic operations of the organization and ensures the strategic aim and directions of the Strategic Health System Plan (SHSP) are at the forefront of the planning, integration and funding recommendations to the Board.

The Board provides ongoing direction to the CEO through:

- Regular business and education meetings;
- Board committees;
- Policy direction; and,
- Performance appraisal.

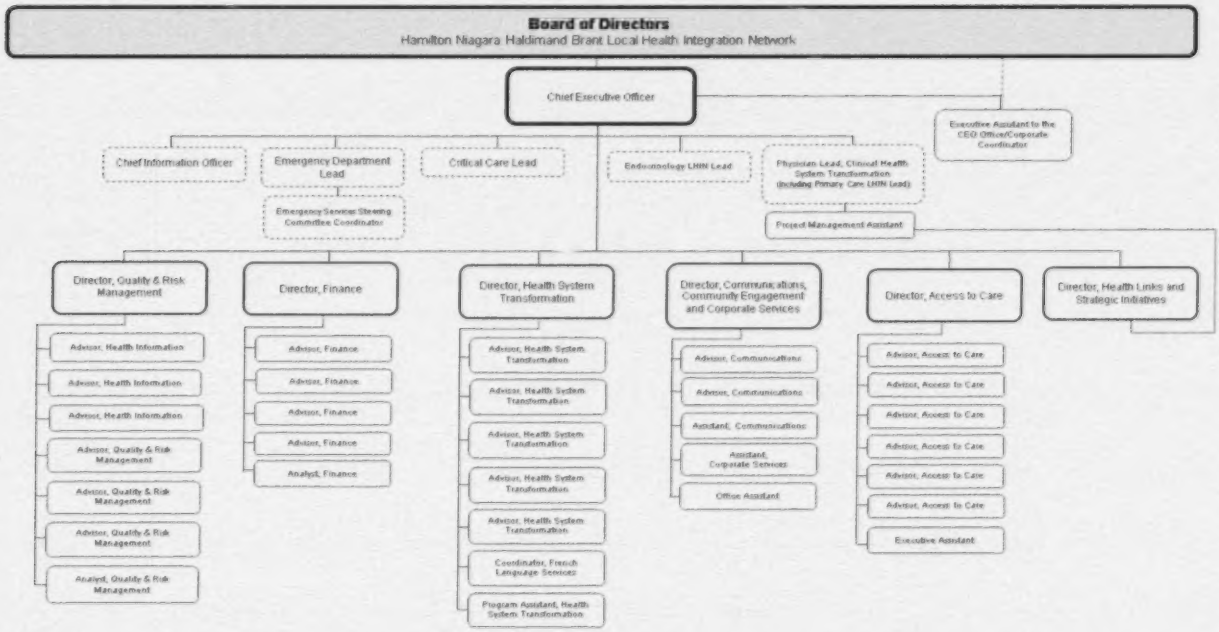
Continued Evolution of the HNHB LHIN

Our Organization

HNHB LHIN staff is committed to and passionate about working toward achieving the LHIN vision - a health care system that helps keep people healthy, gets them good care when they're sick, and will be there for our children and grandchildren – and the LHIN's strategic aim of dramatically improving the patient experience through quality, integration and value. It is this vision and strategic aim that guide staff in carrying out the duties of their roles.

The structure of roles within the organization is based on the core functions of the LHIN and maximizes the skills, knowledge and expertise of staff. Staff is committed to building capacity and sharing knowledge through participation in local, provincial, and national activities.Staff is guided by the values and principles of the organization including respect, integrity and accountability and to achieve this staff is committed to transparency, collaboration, innovation and real conversations.

HNHB LHIN – Organizational Structure as of March 31, 2015



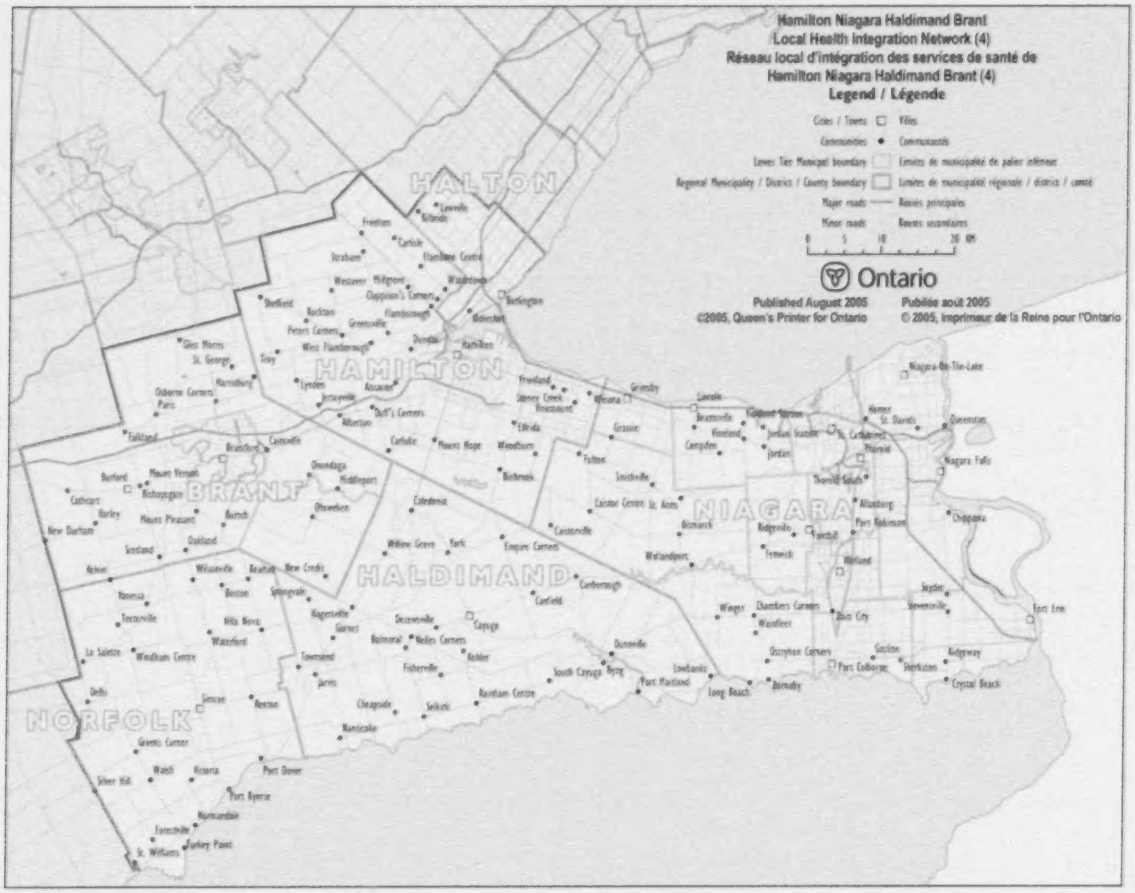
Snapshot of the HNHB LHIN

HNHB LHIN Population

Demographics

The HNHB LHIN, encompassing both rural and urban areas, is approximately 6,500 km² in size. The LHIN is home to approximately 1.46 million people or 10.5% of the population of Ontario. The LHIN population is projected to grow 8.8% over the next 10 years *(Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).*

The LHIN's population is aging. More than 260,000 people age 65 or older live in the LHIN and this number is projected to increase to approximately 355,000 by 2025 – that is a projected increase of more than 35%. Among seniors, the largest growth will be those 75 years and older (Source: Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO).



Socio Demographic Characteristics

The HNHB LHIN has a diverse population. For 17% of residents, neither English nor French is their first language. Francophone, First Nations, Inuit, Métis, and urban Aboriginal people are recognized populations in the HNHB LHIN. Compared to Ontario, the HNHB LHIN has a lower percentage of immigrants (19%) and visible minorities (10%). *(2011, National Household Survey, Statistics Canada).*

About 2.4% of the LHIN population is defined as Francophone. Almost 80% of the LHIN's Francophone population resides in Hamilton and Niagara. In Niagara, Welland and Port Colborne have the highest percent of Francophone population compared to the overall population among communities within the LHIN *(Source: 2011 Census of Canada, Statistics Canada).*

There are two Aboriginal reserves in the LHIN – Six Nations of the Grand River Territory, which has the largest population of all First Nation communities in Canada, and **Mississaugas of the New Credit First Nation**. The total registered Aboriginal population in the LHIN is approximately 28,000 people, approximately 50% of whom live on reserve. Due to a lack of data and information, Non-Status, Métis, and Inuit populations are not included in these population estimates *(Source: Community profiles, Aboriginal Affairs and Northern Development as of February 2015).*

In many ways, the LHIN population is similar to the provincial population on a variety of socio-demographic characteristics. Within the LHIN however, there are some significant differences between and within geographic regions. While the HNHB LHIN has a similar population proportion of low income families as Ontario, Hamilton rates of low income are higher than the provincial average. Compared to the Ontario average, the LHIN has a higher percentage of lone parent families and a lower percent of adults with high school and post-secondary education.

	HNHB LHIN	Ontario
Total Population (2015)	1,457,688	13,894,109
Senior population, age 65+ (2015)	18.0%	15.8%
Population with English mother tongue	81.3%	70.4%
Population defined as Francophone	2.4%	4.8%
Population who are immigrants	19.2%	28.5%
Population who are recent immigrants (arrived between 2006-11)	1.9%	4.0%
Populations who are visible minorities	10.3%	25.9%
Population of Aboriginal identity	2.8%	2.4%
Unemployment rate (age 15+)	7.1%	7.8%
Population in low income (before tax) all persons	13.6%	14.5%
Families (with children) headed by a lone parent	17.4%	16.7%
Population (age 25-64) with completed post-secondary education	63.8%	67.2%

*(Sources: *Population Projections, LHIN, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO. **2011 Labour Force Survey. Remaining indicators based on 2011 Census of Canada and 2011 National Household Survey, Statistics Canada.)*

Health Status

Health can be measured as perceived or self-reported indicators as well as the presence or absence of disease or injury. Self-reported health can show aspects of health not captured in other measures. **More than 13% of LHIN residents rate their health as 'fair' or 'poor'**, which is higher than Ontario's rates. In addition, more LHIN residents say they are limited in their activities because of a physical or mental condition or health problem and have pain or discomfort that prevents them from engaging in activities *(Source: Statistics Canada, Canadian Community Health Survey, 2013).*

Illness, Disease and Death

LHIN residents have higher incidents of high blood pressure, chronic obstructive pulmonary disease (COPD), and arthritis compared to the province. Approximately 20% of HNHB LHIN residents have been diagnosed with high blood pressure or arthritis, and 6% with COPD. The percentage of residents with asthma is 8% and diabetes is nearly 8%, which means that the HNHB LHIN rates are slightly higher than Ontario rates *(Source: Statistics Canada, Canadian Community Health Survey, 2011-12).*

Death rates reflect the overall health of the population. **Heart disease, lung cancer, and stroke were the top three leading causes of death.** Potential years of life lost rates are useful for measuring the number of years of life "lost" from deaths that occur "prematurely" (i.e. before age 75). The rate of potential years of life lost within the HNHB LHIN are higher than provincial rates *(Source: CIHI Health Indicators Interactive Tool, 2010)*

Health Practices and Preventive Care

Poor health practices, such as physical inactivity or poor dietary habits, may increase the risk of chronic disease, disability, and death. **The rates of smoking are nearly 24% in the HNHB LHIN, this is higher than the provincial average of 18%.** Relative to the province, more people in the HNHB LHIN have a body mass index (BMI) indicating they are overweight or obese. *(Source: Statistics Canada, Canadian Community Health Survey, 2013).* In 2013, there was a slightly lower percentage of adults in HNHB LHIN reporting that their alcohol consumption was heavy when compared to the provincial average.

Activities that promote health, prevent disease, and reduce the risk of injury are important elements in the health and wellness of a population. These activities require individuals to be engaged in their health care and can be facilitated through an effective relationship with a primary physician. 94.3% of HNHB LHIN residents have a regular doctor, which is higher than the Ontario rate of 91.2%. Preventive health care services, such as good hand hygiene practices, or regular health screenings, can help find disease early and over the long-term reduce illness and death. Another example is immunizations. There were approximately 33% of HNHB residents who received a flu shot in 2013, similar to the Ontario average. *(Source: Statistics Canada, Canadian Community Health Survey, 2013).*

Summary

The LHIN covers approximately 6,500 km² and encompasses Brant, Burlington, Haldimand, Hamilton, Niagara and most of Norfolk. With **approximately 1.46 million people**, it includes small rural communities and large urban centres, with a population that is culturally and linguistically diverse.

Relative to Ontario, the LHIN has a higher percent of:

- People reporting 'fair' or 'poor' overall health
- People limited in their daily activities
- People who smoke regularly
- People who are obese,
- People diagnosed with arthritis,
- People with chronic obstructive pulmonary disease,
- People with high blood pressure
- Premature death

Engaging our Communities

Community engagement is a core function of the LHINs and is written into the *Local Health System Integration Act (LHSIA)*, 2006 – the legislation that created LHINs. As part of its work, the HNHB LHIN engages a diverse range of people, including residents, health professionals, and those who are actively involved in the health system. This includes engaging with members of the Aboriginal, First Nations and Francophone communities. The LHIN recognizes, respects, and seeks to understand and address the unique needs of its diverse communities.

Aboriginal Health Engagement

The HNHB LHIN is involved in ongoing engagement and dialogue with First Nations and Aboriginal communities to create opportunities for patients and families to voice their opinions and participate in shaping both current and future health programs and services. The knowledge gathered from community member experiences is fundamental in developing the LHIN's population-based strategy aimed at improving the health and wellness of Aboriginal Peoples. Through harmonizing the efforts of traditional and non-traditional health practices, solutions can be created that align with cultural identity, holistic health and community values.

Collaboration with the HNHB LHIN's Aboriginal Health Network (AHN) enables the development of culturally safe and inclusive health care environments that translate into improved patient experiences and positive outcomes. The AHN meets monthly to share expertise, convey local health issues, and provide input to the LHIN regarding approaches to planning, community engagement, and system performance.

In 2014-2015, the AHN continued progress towards the priorities identified as part of a three-year action plan:

1. Reducing youth suicide and strengthening services to support youth mental health.
2. Reducing the Aboriginal rate of diabetes and other chronic conditions.
3. Reducing domestic violence and supporting strong, stable, responsible families.

To support these priorities the AHN engaged in a variety of activities during 2014-2015:

- As part of the AHN mental health initiative to reduce youth suicide and strengthen youth mental health support services 45 individuals received trainging in Safe Talk Suicide Prevention, 26 individuals in Applied Suicide Intervention Skills Training (ASIST) Version 10, and 103 individuals in Mental Health First Aid.
- The AHN Walk the Talk Health and Wellness Program received ongoing support as it continued to promote healthier lifestyles among aboriginal health workers through healthy diets, tobacco cessation, physical activity and stress management.
    - Southern Ontario Aboriginal Diabetes Initiative (SOADI) released a cookbook titled 'Food Is Our Medicine; Making it Sacred' to support Walk the Talk.
- Delegates from five AHN organizations participated in a two-day Kanawayhitowin Facilitator's Training: Taking Care of Each Other's Spirit. The purpose of the training was to raise awareness about abuse against women in Aboriginal communities and provide families, communities, and front line workers with resources and strategies to address abuse in their community.

Cultural Sensitivity

In follow up to the Ontario Federation of Indian Friendship Centres (OFIFC) Cultural Sensitivity training completed by LHIN staff in 2013-14, the LHIN developed a plan to build on these cultural learnings that took a deeper look at how this knowledge translates into the work that the LHIN does. The LHIN committed

to enrolling a minimum of five staff members, as well as all new staff joining the LHIN, in Southwest Ontario Aboriginal Health Access Centre's Indigenous Cultural Competency training for Ontario Healthcare Professionals. The training is founded in principles of respect, safety, and trust, and aims to create an interactive and facilitated environment for health professionals to expand their knowledge of Canada's Indigenous Peoples, increase self-awareness, and develop skills to work more effectively with Indigenous Peoples.

Between November 2014 and March 2015, 16 LHIN staff including the CEO, four Directors, and 11 LHIN Advisors completed this training. The LHIN continues to support the need for broader expansion of cultural competency training and values the education these sessions offer. They are important to providing the best care possible for Aboriginal Peoples in a manner that considers and respects their culture and beliefs.

Patient Navigation

Three full-time Aboriginal Patient Navigator positions are currently funded through De dwa da dehs nye's Aboriginal Health Access Centre (DAHAC) in three LHIN zones: Hamilton, Brantford and Niagara. The role is intended to work with Aboriginal and mainstream health and social service organizations, the HNHB Community Care Access Centre (CCAC) and hospitals across the LHIN to help Aboriginal clients, caregivers and their families navigate the health care system after admission to hospital.

Aboriginal Patient Navigators
Making a Difference: A Family's Experience

A young autistic boy spent time in the hospital ICU after becoming ill. With family by his side as much as possible, his father was struggling to balance school, work, and taking care of his son. The father stated that "the child had lost his spirit". Once the Aboriginal Patient Navigator was introduced to the family, they were able to visit the boy when the father was away, connect the family to volunteers in the hospital, and refer to a music therapist. The young boy and his family were very appreciative of these supports and saw great improvements in the child's overall wellbeing.

Between February and December 2014, 1,318 individuals from across the LHIN received improved access to culturally appropriate services as a result of this program. Through participation in discharge planning meetings, essential resource support and referrals, and assisting patients in their transition from hospital to community, Aboriginal Patient Navigators are able to "enhance the safety of Indigenous service users during health care provision" (*Source: Smylie (2015). First Class People, Second Class Treatment*).

Traditional Healing

During the past year consultations with Aboriginal communities both on and off-reserve were held to identify ways of blending traditional healing and cultural practices with mainstream health programs and services.

On December 5, 2014, the AHN hosted "Traditional Healing in Today's Health System". The purpose of this session was to create a culturally safe forum for Aboriginal patients and their families to share personal stories and participate in meaningful discussion regarding access to traditional healing services. Learnings

from the day (summarized in a Report to Community which is available on the LHIN's website) offered valuable community feedback which will be used to inform and develop future goals and strategic priorities by the AHN.

Key recommendations in the report include:

- Improving awareness and understanding of Aboriginal cultures by engaging with mainstream providers, offering ongoing cultural sensitivity training, and creating culturally accommodating hospital environments.
- Improving access to traditional services by increasing access to Traditional Healing and expanding the Aboriginal Patient Navigator Program.
- Exploring funding opportunities to offer financial support for Traditional Healers.
- Engaging Aboriginal communities regularly and continuing to create forums that empower people to share their stories, learn about their health system, and ask questions.

Francophone Health Engagement

The *French Language Services Act (FLSA), Ontario, 1986*, recognizes the contribution of the French speaking population to the historical, cultural, and linguistic heritage of Ontario. The *FLSA* guarantees the right of French speaking Ontarians to communicate with the government and receive services in French. Under the requirements of the *Local Health System Integration Act (LHSIA)*, Ontario, 2006, the LHIN is responsible for ensuring that the French-speaking population has equitable access to a full range of health services in French. To this end, the LHIN funds, plans and promotes French language health services, and engages the French speaking community in the process. French speaking residents and stakeholders know their communities best and the goal is to ensure the best outcomes for French language health services, acknowledging and respecting diversity within Francophone communities.

Partners in Health

The HNHB and Waterloo Wellington (WW) LHINs, and the Entité de planification pour les services en français dans les régions de Waterloo, Wellington, Hamilton, Niagara, (French Language Planning Entity – 'Entity') signed a five-year funding and accountability agreement effective April 1, 2011. The agreement sets out the roles and responsibilities of each party related to the provision of advice to the LHINs by the Entity on:

- Methods of engaging its Francophone community.
- The health needs and priorities of its Francophone community, including the needs and priorities of diverse groups within that community.
- The health services available to its Francophone community.
- The identification and designation of health service providers for the provision of French language health services in the HNHB and WW LHINs.
- Strategies to improve access to, accessibility of, and integration of French language health services in the local health system.
- The planning for, and integration of, health services in French in the HNHB and WW LHINs.

The accountability agreement required the establishment of a Joint Liaison Committee to develop appropriate mechanisms for ongoing dialogue and collaboration and the development of a Joint Annual Action Plan that sets out the objectives, priorities and actions each party will undertake in the current fiscal year.

Francophone Community Engagement

The HNHB LHIN participated in three meetings organized in collaboration with the Entity to promote the new bilingual Adult Day Program which serves older adults and people with disabilities in Hamilton.

The LHIN also participated in community meetings and events for the Francophone community to promote health services and programs and to listen and understand the needs of the population. Coming out of these meetings was the development a brochure outlining the programs and services available to the Francophone community.

French Language health service providers (HSPs) must develop an engagement strategy to understand the Francophone community and its stakeholders, and integrate their specific needs into the planning process. The LHIN actively participated in Francophone collaborative planning discussions (such as Table interagence francophone du Niagara and Table interagence of Hamilton. These engagement sessions were collaborative planning tables allowing providers to partner and promote their services within the community.

Listening, Learning and Developing Services

In response to an identified need and as part of the community Mental Health funding strategy , the LHIN directed $19,145 to Centre de santé Communautaire Hamilton/ Niagara for a LHIN-wide French Mental Health Promotion and Resilience strategy. The strategy will expand existing training (e.g. Mental Health First Aid, Safe Talk, Applied Suicide Intervention Skills Training (ASIST), and Talking About Mental Illness (TAMI)) into French for families, caregivers and other non-health professionals across the LHIN.

The LHIN also engaged all health service providers to increase knowledge and awareness of French language services in order to improve access to quality health services in French and to assist them in planning and implementing French language services for their Francophone clients.

Continuing to explore solutions to improve access to health services, LHIN facilitated the implementation of diabetes education sessions through Ontario Telemedicine Network (OTN).

In response to a need expressed by members of the Hamilton Francophone community, the LHIN continues to work with the Entity, the community and Long-Term Care Homes (LTCHs) to develop and implement a strategy to increase access to LTCH beds for French speaking individuals in Hamilton.

Physician Engagement

Physician engagement is a key component in planning and implementing many of the strategies across the LHIN. Over the past several years, this LHIN has had a variety of active physician networks, and various ad hoc groups, which include both specialists and family physicians.

The Chief Medical Leaders (CML) group has been meeting for more than seven years, and is comprised of Chiefs of Staff, or Vice President Medical from each hospital. The monthly meetings review wait time data, access to care, and provide input on many of the new initiatives being implemented across the LHIN. Recently, this group provided advice on preparing for Ebola and was critical to the successful implementation of the Life or Limb program. This group also provides the opportunity for smaller hospitals and larger academic hospitals to discuss LHIN-wide issues, including call-coverage, and to work together to improve the patient experience across the LHIN.

The Diagnostic Imaging Network (radiologists) and their orthopedic colleagues formed a subgroup to develop appropriateness guidelines for the use of CT/MRI versus Plain Film x-rays for patients being assessed for potential joint replacement surgery. These guidelines were communicated to all Primary Care physicians in the LHIN. An education event was held with family physicians, Orthopedic surgeons (joint replacement and spine), as well as a neurosurgeon to discuss warning signs and appropriate investigations for their patients. This approach, which incorporated the Choosing Wisely Canada (CWC) guidelines and informal discussions, was well received by those in attendance.

CWC recognizes the importance of educating and engaging patients so they can make informed choices about their care. CWC helps patients, their familes and physicians, understand when procedures are necessary (and when they are not), and what patients can do to improve their health.

The HNHB Diagnostic Imaging committee has created a detailed communication plan targeted to raise awareness within primary care providers in the community, as well as within its hospitals, to reduce unnecessary testing for patients, while aligning work and patient education with the principles behind CWC.

The LHIN's Primary Care Network (PCN), consisting of Primary Care Physicians as well as the 11 family physician Health Link leads, regularly provided input to the clinical strategies being implemented across the LHIN, as well as helped LHIN staff and providers better understand how meeting the needs of primary care and family physicians would help them to help their patients. For example, the PCN provided concrete examples to the HNHB CCAC as to how they could improve the patient experience including the standardization of the CCAC Referral Form which has been implemented across the LHIN.

To improve the uptake by patients with diabetes to attend one of the LHIN's Diabetes Education Programs (DEPs), members of the Primary Care Network met with DEPs staff and leads to better understand the services that could be provided to patients with diabetes and also shared their advice and suggestions with the DEPs. This collaboration has led to a dramatic increase in patient referrals to DEPs.

2014-2015 saw increased activities and responsibilities related to health care planning and preparedness for the Pan and Parapan Am Games taking place in Toronto and the Greater Toronto-Hamilton Area (GTHA) in July and August 2015. The Games footprint has been divided into four zones and the HNHB LHIN has taken the lead for West Zone planning. This Zone includes the HNHB, Mississauga Halton (MH), and Central West (CW) LHINs. Working closely with staff at all three LHINs, the HNHB was tasked with ensuring that hospital and community partners, as well as consultants and Primary Care physicians were well aware of the implications of the various events hosted across the three LHINs. The planning and preparedness being undertaken for the Games will be valuable and provide great learnings and processes for future emergency preparedness.

Health Professionals Advisory Committee

The Health Professionals Advisory Committee (HPAC) continued to provide insights and perspective to the LHIN. Focused on optimizing interprofessional care and scopes of practice within the LHIN, in 2014-2015 HPAC focused primarily on the mental health and addiction sector, and provided valuable advice and input into the LHIN's Mental Health and Addictions planning process.

In an effort to continue to develop a robust membership which would meet the needs and focus of the Committee, four new members - all with a background in mental health - joined the committee in 2014-2015.

The Committee completed a value stream mapping exercise to look at the various transitions for patients with mental health and addictions within the LHIN and the information will provide clear areas of focus for HPAC to assist with the HNHB LHIN's Mental Health Strategic Plan.

HNHB LHIN's Strategic Health System Plan (SHSP) – Dramatically improving the patient experience through Quality, Integration and Value

2014-2015 marked the mid-point of the HNHB LHIN's five-year Strategic Health System Plan (SHSP).The SHSP has seen the ongoing development of a health care system that dramatically improves the patient experience through quality, integration and value. The continued actions within the SHSP embed a culture of quality throughout the care system, integrate service delivery, and evolve the role of the LHINs to become health system commissioners.

The SHSP is building an evidence-based, integrated and person-centred health care system, that focuses on:

- The health care experience of the individual;
- The health of a defined population; and,
- The per capita cost for the population.

System-wide Quality Improvement

The strategic direction of dramatically improving the patient experience through embedding a culture of quality throughout the system continues across the HNHB LHIN. The LHIN, its health service providers and partners continue to engage in quality improvement work - understanding opportunities, planning and implementing initiatives, monitoring data, and making necessary changes as required - with the goal of improving patient care.

There are a variety committees, working groups, and networks across the LHIN focused on continuously improving health outcomes for people. The Emergency Services Steering Committee (ESSC), Regional Palliative Care Network, Patient Flow Steering Committee, Vision Steering Committee, and Mental Health and Addictions Steering Committee areall putting the patient first .

The Quality Guidance Council (QGC) is chaired by the CEOs of the HNHB LHIN and the HNHB CCAC. Members represent all sectors of the health system and provide thoughtful insights, ideas and input to help create and sustain the culture of quality. In 2014-15, there were a number of notable areas of focus within the LHIN quality plan endorsed and supported by the QGC.

Quality Obligations

Health service providers (HSPs) were required to develop and submit quality plans outlining their goals and initiatives to improve health outcomes and the care experience for patients, clients, and residents. The quality plans were reviewed by LHIN staff and common themes identified. The plans indicated that many organizations were working on enhancing the care experience; increasing staff and volunteer satisfaction; improving access, transitions, and flow for patients through the system; ensuring good stewardship of financial and other resources; and monitoring quality indicators.

HSPs also submitted a board-approved policy on quality, and a balanced scorecard of key performance indicators. Submission and review of these documents created opportunities for the LHIN to provide feedback and engage with its funded organizations in important dialogue about quality.

Deeper examination of the quality plans, scorecards, and policies will be conducted in 2015-16 to identify knowledge translation needs and to further strengthen the connections between provider planning, performance management, and LHIN commissioning.

Patient Experience

Creating a positive health care experience for patients, residents and clients is of critical importance to the HNHB LHIN and its providers. An individual's perception of their health experience is influenced by all aspects of care and service.

In 2014-15, the LHIN in consultation with the QGC drafted a patient experience framework, which will be used to guide LHIN work and will be rolled out as a resource to HSPs in 2015-16. Based on discussions with the QGC, a local obligation was included in the 2015-16 Service Accountability Agreement amended schedules for all health service providers requiring the collection and reporting of patient experience data - notably the patient perception of overall satisfaction and involvement in care.

Health Quality Ontario was one of many organizations that undertook patient experience surveys in 2014-2015. The aggregate system-level data from these surveys will be helpful to the LHIN team as it looks for further opportunities to improve patient experience across the LHIN.

Performance Management

The Performance Accountability Policy outlines principles to guide performance management and sets out a clear relationship between the LHIN and HSPs, the role of governance in performance improvement and identifies the steps to address performance challenges.

The Policy helps answer key questions related to effectiveness, efficiency and quality:

- Are health service providers delivering what they're supposed to be delivering? (Effectiveness)
- Are health service providers delivering services as efficiently as possible? (Efficiency)
- Are there some things that other health service providers can do better? (Quality)

Recognizing the importance of monitoring service delivery volumes, efficiency, and good stewardship of resources the LHIN continued its efforts to create a robust performance management system. The LHIN and HSPs are evolving measurement plans to consistently include indicators of health outcomes and ensure alignment with strategic directions. To this end, LHIN staff is engaged in on-going discussions regarding the development and standardization of key metrics for various programs and functional centres. Performance management is crucial to ensuring the best health care services and programs are available for people when they need them.

Enterprise Risk Management

The LHIN uses an Enterprise Risk Management (ERM) approach to identify, assess, mitigate and communicate key risks in the LHIN.

Key elements of the ERM policy include:

- Monitoring strategic, operational, financial and reputational risk of both the health service providers and the LHIN and it is the responsibility of staff at all levels of the organization to identify risk;
- Staff will consult with HNHB LHIN leadership to determine whether a risk will be elevated to the Ministry of Health and Long-Term Care (MOHLTC);

- Risks will be brought forward to leadership on a regular basis; and,
- Each risk will be updated until the risk is mitigated through risk management plans.

The number and complexity of HSPs in the LHIN requires prioritization based on identified risks. The LHIN developed and implemented a methodology to rank agency risk on a quarterly basis to assess contractual compliance, key performance indicators, and core financial indicators.

The LHIN regularly reports risks to the Board's Quality and Safety Committee and the MOHLTC. Monitoring organizational risk is one of the ways LHINs work to ensure value for money, access to services and access to the best patient care for people and their families.

Integration – Health Links as a new model of integrated care delivery

As part of its SHSP the HNHB LHIN has identified three key strategic directions supporting its strategic aim of dramatically improving the patient experience through quality, integration and value. Improving the patient experience by integrating service delivery begins at the local level - integrating care delivery for a group of individuals - one person at a time. Integrated service delivery means the system will focus on patient-centered care including supporting the Health Link model of care.

In February 2015 the Minister of Health and Long-Term Care announced *Patients First: Action Plan for Health Care*, the next phase of Ontario's plan for changing and improving Ontario's health system with a focus that includes end of life care and mental health and addictions. It builds on the progress made since 2012 under the original Action Plan For Health Care and focuses on putting patients' needs first. Putting patients first lays the foundation for Health Links - a model of care to improve care for high-needs patients, with an initial focus on seniors and patients with chronic conditions.

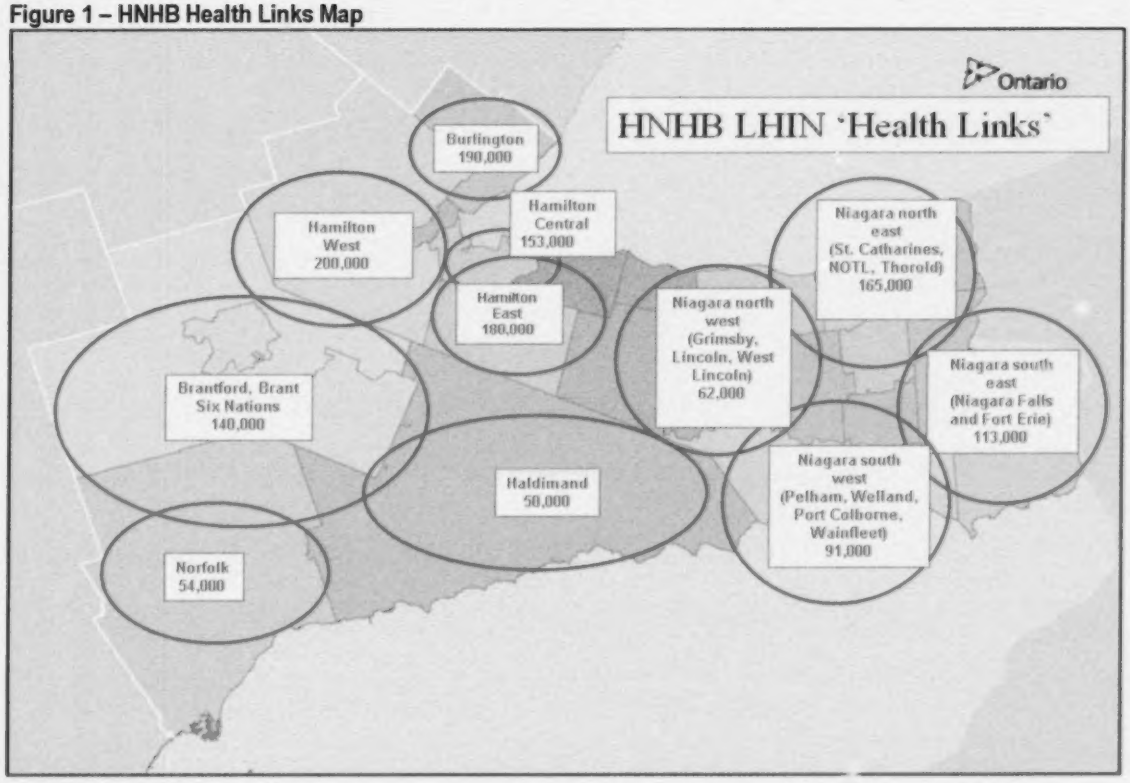
Health Links is the a catalyst for better quality of care. It represents a cornerstone in the primary care system by connecting patients to community-based care by using resources more efficiently and effectively. Health Links respects local variations and needs, but abides by a core set of principles including:

- Patient-centered care;
- Patient engagement including patients, families and caregivers ;
- Broad provider participation;
- Alignment and integration of care transition points; and,
- Planning that incorporates all aspects of a patient's needs and objectives.

Foundational Work

Reflecting the geography and diversity of the LHIN population, 11 prospective Health Links (the most of any LHIN in the province) were identified. At the end of the 2014-15 fiscal year, 10 of 11 Health Links were approved and operational, with approval was pending on the final Health Link.

Figure 1 – HNHB Health Links Map



Identifying the Health Link Person

The LHIN partnered with local experts to identify those people who would most likely benefit from participation in Health Links. Based on data available from 2012, 2,292 were people identified across the LHIN who met the following criteria - four or more emergency department visits and three or more hospital admissions in the past year. In addition, Health Link coordinators developed partnerships with hospital Emergency Departments and in-patient staff and Primary Care Physicians to identify additional people based on more current information, who would benefit from Health Links.

Local Challenges, Local Solutions

A LHIN-wide strategy was developed to ensure the successful implementation of Health Links bringing together local committees and working groups to oversee and provide guidance and recommendations including:

- A Steering Committee comprised of Executive Leads to ensure alignment of local Health Link directions with provincial and LHIN priorities;
- An Operations Committee comprised of Project Leads to identify and disseminate best practices across the Health Links; and,
- Working Groups to develop a LHIN-wide approach to:
    - The reporting of standard indicators;
    - Care coordination; and,
    - Plan for an information technology solution to sharing the care plan with patients and those people within their circle of care.

Major Initiatives

Care Coordination

The LHIN reached out to providers, partners, and stakeholders to begin conversations that would ultimately bring together the care coordination that is at the centre of Health Links. In 2014-15, health providers completed 236 coordinated care plans for high needs patients. These care plans adopt best practices related to person-centred care planning.

Community Paramedicine

The LHIN continued to facilitate partnerships between Health Links and local Emergency Medical Services teams to explore expanding the role of paramedics to better support the complex needs of patients. Emerging models within Health Links see paramedics visiting patients in their communities or at home to assist them in better managing their chronic conditions. This approach to patient care is intended to reduce visits to the hospital as well as ensure the appropriate use of primary care and community resources.

Clinical Program Integration

Continued clinical services planning directly aligns with the HNHB LHIN's Strategic Health System Plan for a local integrated health care system where individuals experience care that is coordinated, of the highest quality, cost effective and results in better outcomes for the population.

The LHIN follows a consistent process to develop LHIN-wide integrated clinical programs. This process has achieved great success with measurable outcomes as evident through the Integrated Cancer Clinical Services Plan, Integrated Vascular Clinical Services Plan and Thoracic Clinical Services Plan.

Success is attributed to a defined process with clear expectations, strong physician engagement and leadership, and strong administrative and organizational leadership. Clinicians assess each patient and determine how urgent their need for treatment is, ranging from more urgent cases (Priority 1 or P1) to less urgent, non-emergency cases (Priority 4 or P4).

The key to LHIN-wide integrated clinical programs is "one program across multiple sites." All residents across the LHIN should have access to a coordinated program with the same approach to care delivery and the same quality standards. This requires increased standardization and the reduction of clinical variation between providers. This is accomplished by using common definitions and patient flow processes, common care models and quality improvement process based on leading practices and, common outcomes, goals, deliverables and metrics.

Orthopaedics

The Integrated Orthopaedic Capacity Plan (IOCP) has led to the development of standardized orthopaedic order sets, care pathways, and patient education material across hospital sites in the LHIN ensuring consistency of quality care provided to patients in the LHIN.

The LHIN has also implemented collaborative partnerships with hospitals to improve wait times and promote standardization across the LHIN for patients requiring total joint replacement. Specific emphasis has been placed on wait list management, accurate reporting of data, and referral redirection to first available surgeon. Ensuring patients can access the care they need in a timely way is paramount – these areas of focus are making that happen,

Monthly meetings between the LHIN and Orthopaedic/Surgical Directors involved the development of a unified LHIN-wide approach to share best practices and successes to ensure:

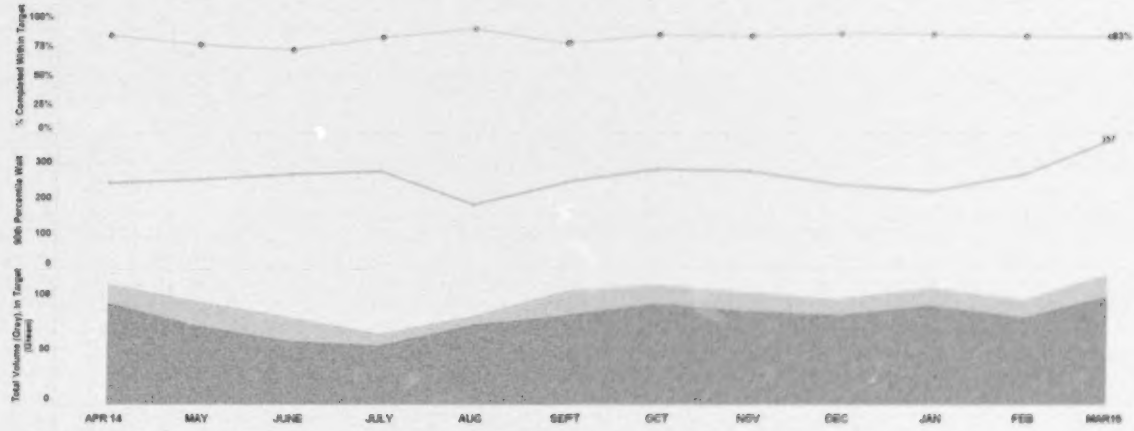
- Increased accuracy of wait time data with a better LHIN-wide understanding of the variation and opportunities for improvement;
- Emphasis is placed on booking individuals with the longest wait times, specifically those patients already waiting beyond 182 days; and,
- Surgeon-specific wait times are shared with all orthopaedic surgeons across the LHIN and it is expected that the surgeon will provide a patient with choice and offer referral redirection to surgeons with shorter waitlist when appropriate.

The HNHB LHIN Orthopedic Leadership Steering Committee has been tasked with sustaining the quality achievements to date as well as establishing deliverables for the future. The Steering Committee has actively participated in the provincial CIAC (Central Intake and Assessment Centre) review led by Cancer Care Ontario (CCO) and the MOHLTC. It is using this opportunity to revisit the vision and structure for the HNHB Regional Joint Assessment Program (RJAP) in an effort to incorporate best practices and look for opportunities to find efficiencies in the CIAC structure and operations. Ultimately, the goal is to improve the patient experience and improve wait times.

In 2014-2015 work continued with hospitals on meeting and exceeding the targets provided in the Orthopaedic Scorecard, placing emphasis on wait time targets. Supported by outcome driven leadership and the integration of existing structures, the RJAP identified priority recommendations to further improve wait times, including the adoption of a Wait Time Policy.

For example, in 2005 after deciding with their specialist to proceed with hip replacement surgery, nine out of 10 people in the LHIN waited up to 416 days, or over 13 months. The latest results for fiscal year 2014-15 highlight greatly improved access to these surgeries in the LHIN, where wait times have reduced by 124 days (or four months sooner) from the 2005 baseline (a 29.8% reduction in wait days). This means that 83% of Adult Priority 4 Hip Replacement surgeries were completed within the 182 day target in fiscal year 2014-15.

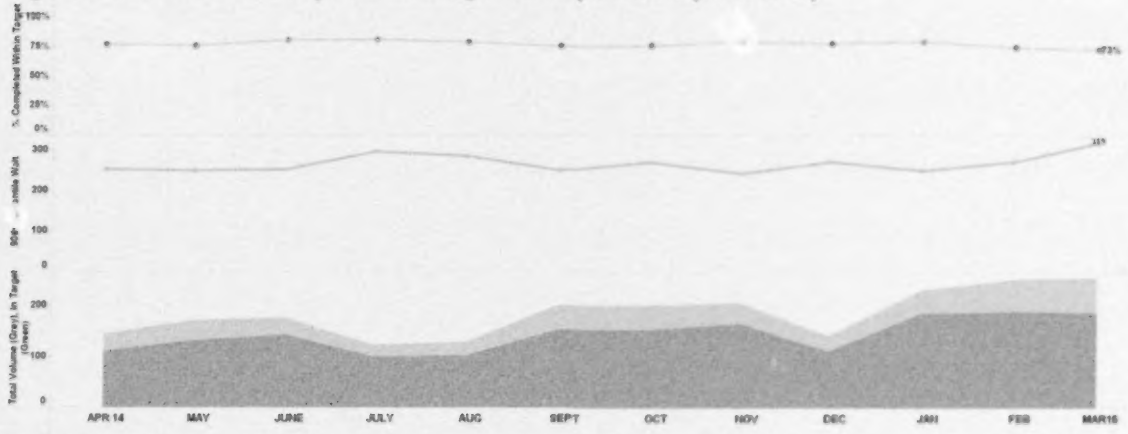
Figure 2 – HNHB LHIN Monthly P4 Monitoring: Total Hip Replacement (FY 2014-15)



(Source: WTIS iPort Access.) Notes: Monthly wait time performance (%Within Provincial Access Target) is coded GREEN if greater than/equal to the HNHB LHIN target, RED if less. Wait times are not shown when there are less than six cases in a month.

In 2005, nine out of 10 people undergoing Knee Replacement Surgery in the LHIN waited up to 450 days, or over 14 months, after deciding with their specialist to proceed with surgery. The latest results highlight greatly improved access to these surgeries in the LHIN, where wait times have reduced by 158 days (or five months sooner) from the 2005 baseline (a 35.1% reduction in wait days). This means that 73% of Adult Priority 4 Knee Replacement surgeries were completed within the 182 day target in fiscal year 2014-15.

Figure 3 – HNHB LHIN Monthly P4 Monitoring: Knee Replacement (FY 2014-15)



(Source: WTIS iPort Access.) Notes: Monthly wait time performance (%Within Provincial Access Target) is coded GREEN if greater than/equal to the HNHB LHIN target, RED if less. Wait times are not shown when there are less than six cases in a month.

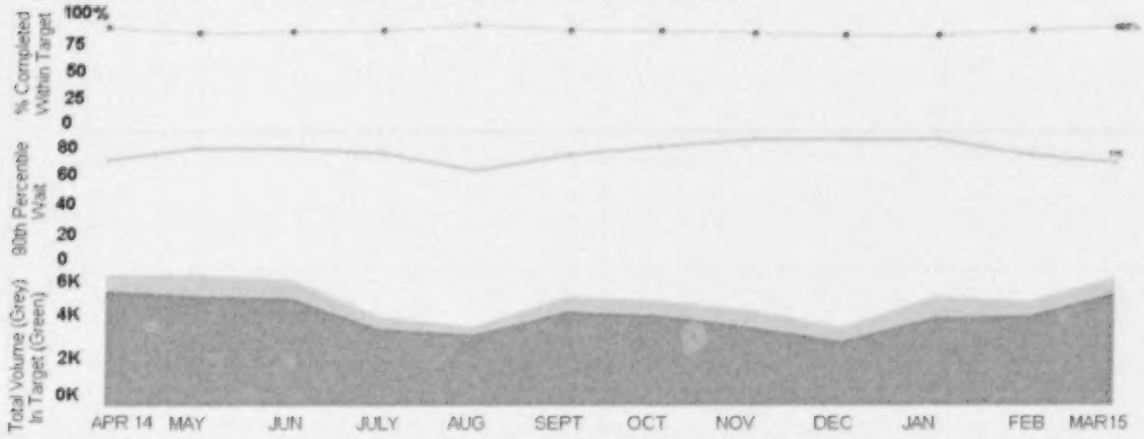
Ophthalmology

Cataract surgeons assess each patient and determine how urgent their need for treatment is, ranging from more urgent (Priority 1) to less urgent (Priority 4).

In 2014-15, 14,522 Priority 4 cataract surgeries were completed within the LHIN - improving people's vision and quality of life.

88% of those Priority 4 surgeries were completed within the 182 day target. That result, while good, is still 2% below the annual provincial target, and reflects the ongoing high demand for cataract surgery within the LHIN.

Figure 4 – HNHB LHIN Monthly P4 Monitoring: Cataracts (FY 2014-15)



(Source: WTIS iPort Access.) Notes: Monthly wait time performance (%Within Provincial Access Target) is coded GREEN if greater than/equal to the HNHB LHIN target, RED if less. Wait times are not shown when there are less than six cases in a month.

To ensure our LHIN continues to make improvements, St. Joseph's Healthcare Hamilton was identified as the lead organization to provide ophthalmology specific physician and administrative leadership within the LHIN by facilitating the use of evidence-based practices while standardizing clinical service delivery.

A LHIN-wide integrated approach to vision care continues to be implemented through the work of the Ophthalmology Steering Committee. The steering committee is focused on and dedicated to positively impacting the patient experience and has demonstrated success in the following areas:

1. Prioritizing those individuals with the longest waits for cataract surgery. Reducing variation in patient's timely access to cataract surgery has been a focused priority at all hospitals.
2. Redirecting patient referrals to surgeons with faster access to care has been able to occur for patients accepting a transfer of their care.
3. Transparent access to cataract surgeon's open case wait lists. This has been achieved at all hospital sites through hospital websites to facilitate physician referrals for patients to surgeons with the most timely access to care.
4. Improvements in standardized patient prioritization coding for cataract surgery based on urgency.
5. Improved understanding of hospital and physician specific data has been achieved through engagement of surgeons and administrative leads,
6. Data quality issues for the Surgical Efficiency Target Program were resolved.
7. A cataract surgery allocation model was collectively developed to allocated resources for surgery based on the population, patient needs and demonstration of quality with defined metrics.

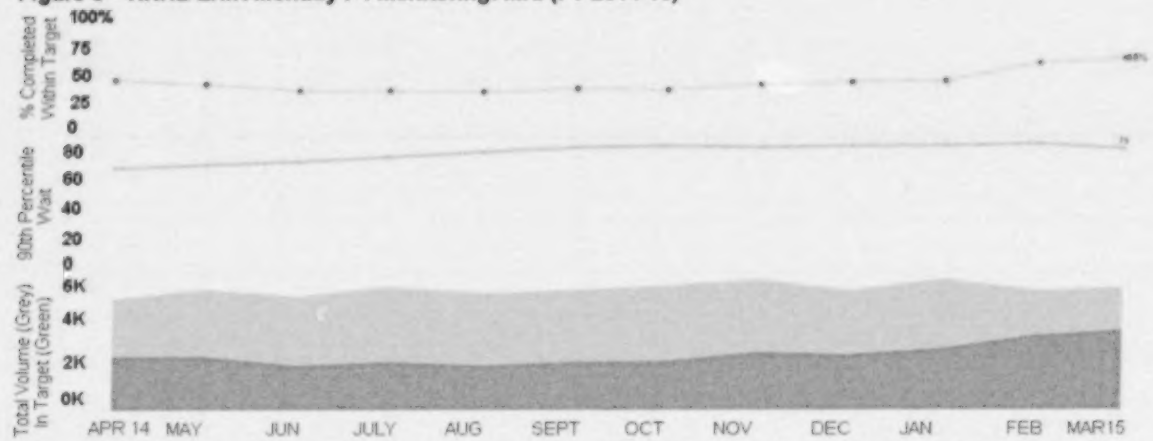
Evidence based, best practice sharing and alignment, continues through monthly meetings of the LHIN-wide Ophthalmology Steering Committee and will be maintained through the leadership of this group.

Diagnostic Imaging

In 2014-15, 64,096 Priority 4 Magnetic Resonance Image (MRI) scans and 37, 931 Priority 4 Computerized Tomography (CT) scans were completed within the LHIN. While those numbers sound impressive, we know we still have a long way to go to ensure people are receiving the timely care they need.

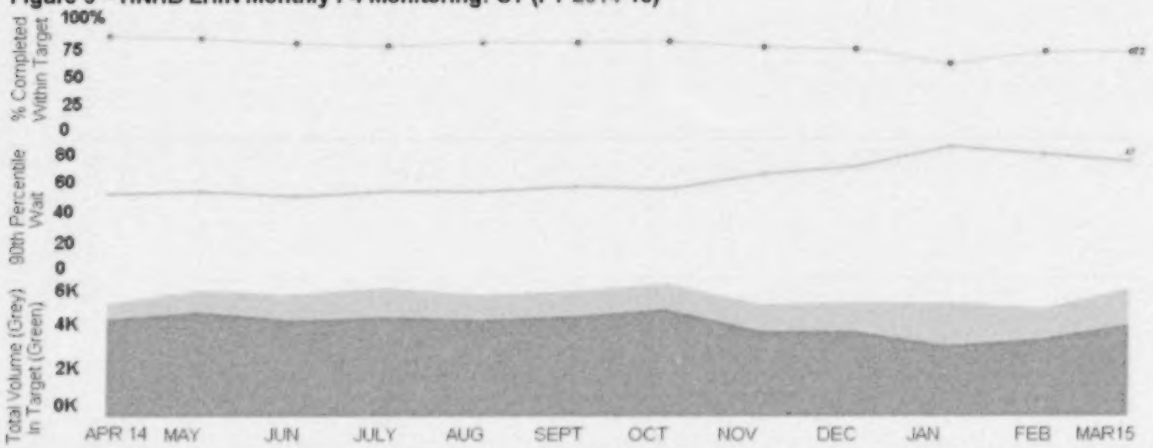
Only 65% of those MRI scans and 63% of the CT scans were completed within the 28 day targets. While we were above 5% above the HNHB LHIN target for MRI scans, we were 10% below the provincial target for CT scans. These results reflect the ongoing patient demand for MRI and CT scans and will continue to be areas of focus and attention for LHIN staff.

Figure 5 – HNHB LHIN Monthly P4 Monitoring: MRI (FY 2014-15)



(Source: WTIS iPort Access.) Notes: Monthly wait time performance (%Within Provincial Access Target) is coded GREEN if greater than/equal to the HNHB LHIN target, RED if less. Wait times are not shown when there are less than six cases in a month.

Figure 6 – HNHB LHIN Monthly P4 Monitoring: CT (FY 2014-15)



(Source: WTIS iPort Access.) Notes: Monthly wait time performance (%Within Provincial Access Target) is coded GREEN if greater than/equal to the HNHB LHIN target, RED if less. Wait times are not shown when there are less than six cases in a month.

The LHIN-Wide Diagnostic Imaging Steering Committee, comprised of physician and administrative representation from all hospitals currently providing MRI and CT services, continued the establishment of collaborative partnerships and evidence informed best practice sharing within and across hospitals.

The LHIN-Wide Diagnostic Imaging Steering Committee worked to positively impact patient experiences through:

1. Patient prioritization for those individuals with the longest waits for MRI and CT scans being seen first, to reduce the variation in timely access to MRI and CT scans within the LHIN.
2. Redirection of patient referrals to CT locations with faster access to care has been able to occur for patients accepting a transfer of their care amongst two collaborative facilities.
3. Transparent physician access to MRI and CT scan wait times at all facilities across the HNHB LHIN has been facilitated through communication with primary care physicians.
4. Review of standardized patient prioritization coding for MRI and CT scans based on urgency.
5. Improved understanding of hospital specific data has been achieved across the HNHB LHIN with engagement of Radiologists and administrative leads at MRI and CT sites.
6. Working with radiologist and orthopedic colleagues a small working group established plain film x-ray recommendations to reduce inappropriate demand for MRI and CT scans for patients being worked up for potential joint replacement surgery. This information was based on evidence informed practice from the Health Quality Ontario Clinical Handbook for Primary Hip and Knee Replacement and is now being communicated across Primary Care physicians within the HNHB LHIN.
7. A Choosing Wisely Canada education event focusing on appropriate use of MRI and CT scans was held in November 2014 bringing together family physicians, orthopedic surgeons (joint replacement and spine), as well as a neurosurgeons to discuss warning signs and appropriate investigations for their patients.
8. Ongoing initiatives to continue to further improve and standardize performance on the MRI Performance Improvement Project 3 dashboard metrics. The MRI PIP Dashboard project works to improve processes and reduce variation across MRI sites by standardizing MRI data and reporting.
9. An MRI allocation model was developed with the LHIN-Wide Diagnostic Imaging Steering Committee to allocate resources for MRI scans based on patient needs, magnet operational efficiency, and case complexity with defined metrics.
10. Identification of benchmark times for common MRI scans to identify future opportunities for protocol standardization.
11. Formation of a LHIN-Wide Paediatric MRI working group was initiated to begin to address access and quality of paediatric MRI scans.

Evidence-based, best practice sharing and alignment, continued through bi-monthly meetings of the LHIN-wide Diagnostic Imaging Steering Committee, Diagnostic Imaging Directors Group, and the Diagnostic Imaging Medical Chiefs groups, and will be maintained through the leadership of these groups.

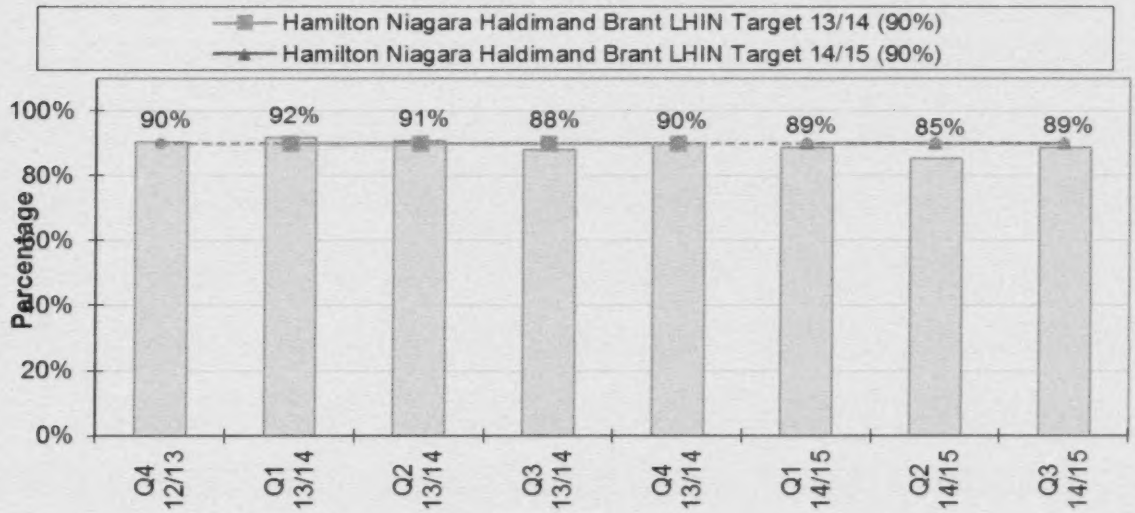
Cancer Surgery

During 2014-2015 the LHIN continued to work closely with the HNHB Regional Cancer Program. The opening in 2013 of the Niagara Health System's Walker Family Cancer Centre at the St. Catharines site has provided an opportunity for Niagara patients to receive care closer to home.

While the LHIN performance is 85% of P4 cases are completed within our access target (slightly below the 90% requirement), the LHIN has seen improvements in several cancer service areas including endocrine, soft tissue sarcoma, head and neck surgery, and gynaecology.

The LHIN continues to remain challenged to meet prostate cancer surgery wait times due to patients choosing to wait for the less invasive Robotic Surgical Procedure. The LHIN and all our hospitals continue to collaborate with the Regional Cancer Centre in Hamilton to look at innovative surgical efficiencies and implement best practice across the LHIN.

Figure 7 – HNHB Monthly P4 Monitoring: Cancer Procedures (FY 2014-15)



(Source: WTIS iPort Access.)

Laboratory Services

The HNHB LHIN Laboratory Medicine Network and Council, and Laboratory Medicine Medical Chiefs continue to work collaboratively to achieve an integrated Regional Laboratory System to provide consistent and standardized quality and care across all hospital laboratory sites for the benefit of our patients served.

A LHN-wide coordinated leadership model for laboratory medicine is in place comprised of nine hospital organizations and one academic centre:

- Hamilton Health Sciences
- Niagara Health System (also provides lab services for Hotel Dieu Shaver Health and Rehabilitation Centre)
- St. Joseph's Healthcare Hamilton
- Brant Community Healthcare System
- Joseph Brant Hospital
- Norfolk General Hospital
- West Haldimand General Hospital
- Haldimand War Memorial Hospital
- McMaster University (academic participation)

The laboratory medical directors for these organizations collectively developed recommendations related to laboratory testing utilization to ensure patients are receiving the most appropriate care:

1. Testing restrictions and discontinuations. A list of tests that have limited clinical utility, are ordered too frequently or inadvertently in some routine order sets has been developed. All laboratories are in the process of either discontinuing or restricting those tests and reviewing order sets to ensure appropriate usage for patients.

2. Standardized laboratory orders related to abdominal pain, chest pain and sepsis. A collaborative LHIN-wide action oriented discussion with emergency room physicians is underway.

3. Review of utilization of additional laboratory tests as specified in the Choosing Wisely Canada Campaign. A current state understanding and interpretation of the Choosing Wisely Canada recommendations continues. The value to patient care will be to decrease the number of blood and other samples taken and to better serve patients. The laboratory medical directors meet quarterly to discuss implementation successes and local test utilization approaches.

4. Through the Standards2Quality program, all hospital laboratories collaboratively and transparently share performance data related to five quality dimensions: access, effectiveness, integration, health and safety, and patient centered care. This program ensures consistent, LHIN-wide, laboratory medicine quality indicator metrics are consistently monitored and reported across all hospital laboratory medicine sites. Improvements across these quality dimensions are strived for through collaborative work amongst all hospitals.

Cardiac – Diagnostic Cardiac Catheterization and Percutaneous Coronary Intervention

In April 2014, the Integrated Heart Investigation Unit (IHIU) at the Niagara Health System (NHS) St. Catharines site expanded services to provide percutaneous coronary intervention (PCI) services in additional to diagnostic cardiac catheterization. The IHIU at NHS is an integrated partnership between Hamilton Health Sciences (HHS) and NHS and operates as a one program–multiple site model. As of December 2014 (the most current data available at time of printing), 1,142 cardiac catheterizations and 276 PCI procedures has been performed at the NHS site.

Successes include:

- Centralized referral and triage at HHS;
- Standardized program-wide policies, procedures, protocols, patient education, staff education and documentation;
- One Medical Director and one Clinical Manager for both sites (NHS and HHS);
- Improved quality by reducing variation and standardizing care delivery models; and,
- Improved transitions through common patient flow processes.

Health System Commissioners

A key strategic priority for the LHIN is to ensure accessible, patient-centered services that also reflect value for money. The LHIN maintains 189 Service Accountability Agreements (SAAs) with HSPs, and monitors fiscal and operational performance. The LHIN is also responsible for working with individual providers on key system-wide priorities, including Mental Health and Addictions, emergency department (ED) wait lists, alternate level of care (ALC), and supporting home and community care.

To drive a greater focus on value, the LHIN adopted commissioning best-practices,a proven international best practice in health care management. Commissioning is a complex process with responsibilities

ranging from assessing population needs and prioritizing health outcomes to procuring products and services and funding bundles of services. As health system commissioners, the LHIN staff and Board continued to enhance health system decisions based on evidence and performance.

Figure 8 – Commissioning Model at the HNHB LHIN:

A key strategic component in the advancement of the LHIN's role in commissioning is provider engagement and the LHIN developed and implemented an engagement plan aligned with Service Accountability Agreement negotiation timelines to ensure significant performance issues are addressed at the time of agreement negotiations.

Successes in Commissioning

In July 2014, the LHIN distributed a survey to all LHIN-funded HSPs and Health Link leads inviting them to share their ideas for opportunities or strategies to improve the patient and family's experience with the local health system as well as identify system pressures or gaps.

Respondents were asked to identify the top three:

- Opportunities or strategies in their respective zones to improve quality, outcomes, integrate delivery and increase value for money; and,
- Service pressures or gaps in their respective zones affecting patient experience and health outcomes.

The four themes identified as areas of pressure across sectors and LHIN zones also aligned with LHIN and MOHLTC priorities:

- Mental Health and Addiction services;
- Home and Community Care;
- Emergency Department (ED) and Alternate Level of Care (ALC) pressures; and,
- Housing.

Using the survey responses and recognizing the provincial priorities that needed to be addressed, the LHIN provided funding in a number of focused areas.

In December 2014 the HNHB LHIN allocated new base funding of $14,694,400 ($17,533,900 annualized) for 2014-15 to support investments in the community sector. The allocation was broken into three specific priorities:

1. Community Mental Health: Up to $2,000,000 (annualized to $4,839,500 in 2015-16), to support phase 2 of the 10-year Comprehensive Mental Health and Addictions Strategy;
2. LHIN Targeted Community Investments: Up to $4,147,900 for LHIN targeted community investments to support government priorities for the community sector, implementation of regulatory amendments to the Home Care and Community Services Act (HCCSA) for agencies other than CCACs to provide personal support services for low acuity clients, and community leasehold expenses; and
3. HNHB CCAC: Up to $8,546,500 to support the HNHB CCAC to achieve and maintain a five- day wait time target for in-home personal support services for clients with complex needs, and for in-home nursing services.

Future Opportunities

There were a number of commissioning opportunities identified in collaboration with HSPs over the last year, including:

- Leveraging funding opportunities to further enhance the LHIN health care system based on population needs and priority health outcomes;
- Further developing and evolving the use of frameworks and tools to assist in planning, allocating, monitoring and responding;
- Maximizing Health System Funding Reform (HSFR) to benefit HNHB residents – fully utilizing Quality Based Procedure (QBP) volumes and funding to HSPs; and,
- Continue to support Mohawk Shared Services to integrate administrative support services in hospitals and develop a plan for reducing duplication in administrative support services in the community.

Advancing Health System Priorities

Mental Health and Addictions

The HNHB LHIN is committed to supporting the development of a person-centred, integrated and coordinated Mental Health and Addictions (MH&A) system. Currently, services are fragmented, spread across several provincial ministries and offered in a variety of care settings – during 2014-15 the HNHB LHIN worked to address these issues to ensure people receive the best care possible.

Mental Health in the HNHB LHIN

- In their lifetime 10-20% of residents will have a substance use disorder.
- 70% of people with mental health issues were diagnosed before age 18.
- 98,000 children and youth do not get the mental health treatment they need.

Strategic Alignment with Provincial Priorities

MH&A has been identified as a priority by both the province and the LHIN. The investments made and successes achieved over the past year are aligned with the strategic pillars of the next phase of Ontario's Comprehensive Mental Health and Addiction Strategy "Open Minds, Healthy Minds: Transforming Mental Health and Addictions Services in Ontario":

- Promote resiliency and well-being in Ontarians;
- Ensure early identification and intervention;
- Expand housing and employment supports, and diversion and transitions from the justice system;
- Provide the right care, at the right time, and in the right place; and,
- Fund based on quality and need.

Building Capacity to Support Individuals with Mental Health and Addictions through Regional Collaboration and Integration

A LHIN-wide Mental Health and Addictions Advisory group, supported by the leadership of St. Joseph's Healthcare Hamilton, was established in 2013 to implement integrated service delivery. Over 2014-2015, the Advisory Group provided leadership for our LHIN-wide system redesign and continued to support the progression in its priority areas:

- Enhanced medical collaboration between psychiatry and primary care;
- Enhanced system performance through LHIN-wide scorecards for both hospital and community;
- Targeted priority populations including Early Intervention and Concurrent Disorders;
- Enhanced integration and collaboration through Health Links and other specific proof of concept projects; and,
- Enhanced services for children and youth through cross-sectoral collaboration with the Ministry of Child and Youth Services (MCYS).

Improved Access to Mental Health and Addictions Services

In 2014-15 up to $2 million in base funding (annualized to $4.8 million in 2015-16) was provided to programs and initiatives that support phase 2 of Ontario's Comprehensive Mental Health and Addiction Strategy. Funding was targeted for integrated initiatives within each of four priority areas:

- Health Promotion and Prevention;
- Early Intervention and Self-Management;
- Treatment Planning, Risk/Crisis Management and Support; and,

- Specialized Care.

The four priority areas identified for 2014-15 and 2015-16 align with provincial, HNHB LHIN, and LHIN 4 MH&A Advisory priorities. They are also representative of the opportunities and pressures identified by HSPs in the 2014-15 Community Engagement Survey (outlined earlier).

This funding will support:

- Expanding existing evidence-informed training for families, caregivers and other non-health professionals across the LHIN, specifically, Mental Health First Aid, Safe Talk, Applied Suicide Intervention Skills Training [ASIST], and Talking About Mental Illness [TAMI];
- Enhance and expand early intervention services for youth ages 17 to 24, including enhancing and expanding existing Early Psychosis Intervention programs, and implementation of a LHIN-wide Mobile Outreach team;
- Integrate and reduce variation between the mobile crisis rapid response teams and crisis intervention training (CIT) with Police across the LHIN;
- Enabling a LHIN-wide Concurrent Disorders capacity building project;
- Enhance existing successful training programs for specialized therapies/interventions for health professionals, including sustaining achieved outcomes and spreading implementation further across the LHIN and within the 3 zones: Dialectical Behavioural Therapy [DBT] training and supervision, and Collaborative Assessment and Management of Suicidality [CAMS] training and supervision;
- Expand Assertive Community Treatment (ACT) team services in Niagara through the implementation of a second ACT team; and,
- Understand the capacity and needs of the regional eating disorder services.

One in five persons, or 280,000 people, in the HNHB LHIN will be affected by mental illness at some point in their lives *(Source: Health Canada, A Report on Mental Illness in Canada, 2002)*. Approximately 42,000 people, or 3% of people in the LHIN, are dependent on alcohol or illicit drugs in a given year *(Source: Prevalence of Co-occurring Substance Use and other Mental Disorders in the Canadian Population, Canadian Journal of Psychiatry, December 2008)*. 30% to 54% of Ontarians diagnosed with a mental illness will also be diagnosed with another mental illness or an addiction *(Source: Making It Happen: Implementation Plan for Mental Health Reform, Ontario Ministry of Health and Long-Term Care: 1999)*. The investments made over the past year aim to make a difference in the lives of these people and their families.

Maternal Child and Youth

Since its inception, the Provincial Council for Maternal and Child Health (PCMCH) has led a number of initiatives tackling key issues affecting the delivery of care to mothers, newborns, children and youth in Ontario. This work is resulting in significant improvements in how care is understood, delivered and evaluated by providers. Where appropriate, the LHIN works in partnership with the PCMCH to implement the resulting recommendations (e.g., in 2011, the implementation of standardized definitions of levels maternal-newborn care).

Improved Access to Midwifery Services

In 2014-15, midwifery services in Norfolk County were expanded through the opening of an additional Midwifery Practice Group (MPG). The opening of this additional MGP improved access for low-risk mothers by making services more readily available and closer to home. It also contributed to improving health

outcomes in underserved populations in rural Norfolk particularly Low German Mennonites, adolescent mothers, and women of low socioeconomic status.

Improving Quality in Maternal Child Health Services through Regional Collaboration and Integration

The LHIN continues to be an active member of and collaborator with the Southern Ontario Maternal Child Health Network (SOMCHN), a network composed of clinical leaders from maternal child programs/services from across HNHB, Waterloo Wellington and Mississauga Halton LHINs.

In 2014-15, the Network began an analysis of maternal child health key performance indicators and successful local quality improvement initiatives. This analysis was completed in order to identify a 2015-2016 initiative for the Network to endorse that would support the reduction of variation and the implementation of best practices across the participating LHIN areas.

Improving Services for Children and Youth with Special Needs and Their Families

The HNHB LHIN is participating as a core partner in Ontario's Special Needs Strategy. The Strategy is aimed at ensuring children and youth with special needs get timely acces to the effective services they need, and to improve the service experience of families.

The work will focus on:

- Identifying children and youth earlier and getting them the right help sooner, through the creation of a new developmental screen for children in the preschool years;
- Connecting families to the right services and supports by implementing service planning coordinators for children and youth with multiple or complex special needs; and,
- Improving access to and making supports and service delivery seamless by integrating the delivery of rehabilitation services (i.e., speech-language therapy, occupational therapy, physiotherapy).

Transforming the Experiences of Children, Youth and Families Needing Help for Mental Health Issues

The LHIN collaborated with Ministry of Child and Youth Services on Ontario's Moving on Mental Health plan to transform the experience of children and youth with mental health problems and their families.

The LHIN has participated in the development of the local Core Services Plan and Community Mental Health Plan under development by the lead agencies already identified in our LHIN - Lynwood Charlton Centre for Hamilton, Reach Out Centre for Kids (ROCK) for Halton, and Haldimand Norfolk Resource, Education and Counselling Help (H-N R.E.A.C.H.).

Health and Wellness

Health is defined by the World Health Organization (WHO) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (1946)*(Source: (Official Records of the World Health Organization, no. 2, p. 100)).*

Health is influenced by complex interactions between the social determinants of health, which are the social and economic conditions that influence the health of individuals, communities and countries (i.e., the conditions in which people are born, grow, live, work, and age)*(Source: Public Health Agency of Canada, 2011; WHO, 2014).*

The Public Health Agency of Canada (PHAC) lists the following as social determinants of health:

- Income and social Status

- Social support networks
- Education and literacy
- Personal health practices and coping skills
- Employment and working conditions
- Social environments
- Physical environments
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender
- Culture

There is mounting evidence that the contribution of medicine and health care on health and wellness is quite limited, and that spending more on health care will not result in significant further improvements in population health. It is becoming increasingly apparent that the most effective way to address health disparities is to address the systematic and unjust distribution of the social determinants of health between populations or communities. This is achieved by taking a population health approach to, and by integrating health equity into, planning (i.e., one in which the scale of intensity of programs, services and policies is proportional to the level of disadvantage experienced by vulnerable and marginalized populations).

Addressing Health Disparities in Target Populations

The LHIN developed and began to implement a health equity planning framework to guide its approach to addressing the social determinants of health and to achieve health equity in its planning activities.

In this planning framework, the LHIN identified two priority populations to focus on – Migrant Agricultural Workers and Refugees. 2014-2015 saw an initial focus on Migrant Agricultural Workers.

Migrant Agricultural Workers

Each year, more than 38,000 legal temporary contract positions are available in Canada for migrant workers. Industry within the HNHB LHIN employs up to 8,000 workers. While migrant agricultural workers are covered by Ontario Health Insurance Program (OHIP), the vast majority do not access health care services and those who do need urgent health care typically go to walk-in clinics or EDs.

The most common health conditions with which migrant agricultural workers present include injury / trauma, and gastrointestinal, musculoskeletal, eye, skin, respiratory, and urinary problems. There are a number of practical and systemic barriers to the workers accessing traditional health care/primary care services including:

- Fear of being sent home or not invited back the following year;
- Lack of awareness of available primary care services and how to access them;
- Inability or reluctance to take time off work;
- Lack of access to a health card; and/or,
- Lack of transportation from their area of work to where services exist.

In 2014-15, the LHIN supported the implementation of a migrant agricultural workers' health program at Brantford's Grand River and St. Catharines Quest Community Health Centres. The primary care-based model is Nurse Practitioner-led and supported by a team of professionals including a Registered Nurse, an outreach worker, a translator, and volunteers. Together, these programs saw 427 clients.

Prevention and Management of Chronic Conditions

Advancing wellness through the prevention and management of chronic conditions continued to be a priority for the HNHB LHIN in 2014-15.

Chronic conditions such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes have been estimated by the World Health Organization to cause 36 million deaths around the world each year (Source Public Health Agency of Canada: Preventing Chronic Disease Strategic Plan 2013-16. *www.phac-aspc.gc.ca › Home › Chronic Diseases › Diabetes. Accessed March 29, 2015).* The number of Canadians with chronic conditions is increasing; the Public Health Agency of Canada estimates that three out of five Canadians have a chronic disease and four out of five are at risk of developing a chronic disease. *(Source Public Health Agency of Canada: Preventing Chronic Disease Strategic Plan 2013-16. www.phac-aspc.gc.ca › Home › Chronic Diseases › Diabetes. Accessed March 29, 2015).*

The increased rate of chronic conditions is due, at least in part, to the fact that Canadians are living longer and the likelihood of having a chronic condition increases with age. However, the rates of chronic conditions are increasing faster among Canadians aged 35-74 years than those aged 65 years and over; and an increasing number of children are being affected by chronic diseases previously only seen in adults. Aboriginal Peoples, a population that is expected to grow at more than twice the rate of the general population (1.8%) are at a greater risk as they experience higher rates of chronic conditions such as heart disease, diabetes, cancer and asthma. *(Source: Elmslie, Kimberly. Against the Growing Burden of Disease. Public Health Agency of Canada 2012. http://ccgh-csih.ca/assets/Elmslie.pdf Accessed March 29, 2015).*

In the 2013 Canadian Community Health Survey, HNHB LHIN residents reported higher rates of chronic conditions such as chronic obstructive pulmonary disease (COPD), arthritis, and hypertension. In addition, 19% of the HNHB LHIN population reported having pain or discomfort that limits normal activity which was higher than the provincial average. *(Source: Statistics Canada, Canadian Community Health Survey, 2013)*

Through the development of coordinated services and integrated care in the community, the HNHB LHIN in partnership with HSPs continuously improved access to services and enhanced the quality of care experienced by patients.

Diabetes

The LHIN assumed the funding and accountability for nine adult and four paediatric Diabetes Education Programs (DEPs) during 2013-2014.

In 2014-2015, the LHIN engaged in ongoing collaboration with HSPs, including primary care, with the purpose of improved coordination, standardization of processes/practices and maximizing utilization to support a more integrated, patient centered. The LHIN worked together with HSPs to develop and implement several initiatives to improve the coordination and delivery of DEPs.

A key component to advance these deliverables was the Leaders in Diabetes committee comprised of representatives from all DEPs, including both ministry and LHIN-funded programs.

The LHIN achieved the three key priorities identified for 2014-15:

1. Improved utilization of all LHIN-funded DEPs. All LHIN-funded DEPs will report a minimum caseload benchmark greater than 50% of provincial target.

- All LHIN-funded DEPs set individual increased client targets to achieve this fiscal year. Four of the DEPs developed and completed improvement plans targeted at increasing caseload benchmarks to be at or above a minimum of 500 clients per DEP team.
- All DEPs are on target for achieving their year-end targets, with three DEPs reporting having met or exceeded targets at Quarter 3.
- LHIN DEPs reported seeing 15,534 clients as of December 31,2014 compared to 17,772 for the full fiscal year of 2013-14. Overall, the LHIN was on track to achieve a 24% increase in client volumes.

2. Improved access to DEPs through standardized referral processes.
    - A standardized Diabetes Referral form developed in consultation with Primary Care was successfully implemented along with a 1-800 number and central intake model in Niagara.
    - A working group was developed to look at a LHIN-wide model and recommendations will be prepared for implementation in 2015-16.

3. Eliminated areas of duplication by shifting resources to areas of need.
    - Duplication of DEPs was identified in the areas of Port Colborne and Fort Erie, with two LHIN-funded DEPs providing similar services in a relatively small area.
    - Niagara Health System and Bridges Community Health Centre worked together to become an integrated DEP to better serve the residents of Niagara.

Bridges Community Health Centre now leads the provision of diabetes services in the Port Colborne and Fort Erie areas, while Niagara Health System has shifted resources to reduce wait times in other areas of Niagara experiencing growth.

Stroke

Since the release of the 2012 Ontario Stroke Network (OSN) Report Card the LHIN has continued to work with providers to better integrate stroke care through services within three identified LHIN zones (Hamilton/Burlington, Niagara, and Brant/Haldimand/Norfolk).

The OSN Report Card represented a positive catalyst for change showing significant improvement for most indicators across the LHIN. In the most recently published OSN Report Card 2012-13, the HNHB LHIN noted improvements in 13 of 19 indicators compared to 2011-12 with notable progress on increasing access to stroke unit care, carotid imaging, clot busting medication (tPA - tissue plasminogen activator) and inpatient rehabilitation.

Hamilton/Burlington

Acute and rehabilitative care services are currently integrated at Hamilton Health Sciences, with plans underway to increase collaborations to further integrate stroke services in Hamilton. Joseph Brant Hospital has completed an application as a telestroke site. The telestroke program will enable 24 hour access to a neurologist for consultation related to the administration of tPA.

Niagara

Discussions related to integrated stroke services in Niagara were initiated with new leadership in 2014-15 with a goal to develop a plan for integrated stroke services in Niagara during the upcoming year.

Brant/Haldimand/Norfolk

In 2014-15 the new integrated stroke unit at Brant Community Healthcare System (BCHS), which serves Brant, Haldimand and Norfolk continued to evolve. The integration of stroke services at BCHS has dramatically improved access to evidence-based stroke unit care, including acute and rehabilitative services. Stroke unit care has shown to reduce the likelihood of death and disability in men and women of any age regardless of stroke severity by as much as 30%. *(Source: Stroke Unit Trialists' Collaboration. Organized Inpatient Stroke Unit, Care for Stroke. Cochrane Database of Systematic Reviews 2007, Issue 4).* Individuals treated in stroke units have fewer complications, earlier recognition of pneumonia and earlier mobilization.

As of March 31, 2015, BCHS has reported the following outcomes related to the integrated stroke unit:

- 85% of individuals diagnosed with a stroke were managed on a stroke unit during their inpatient stay.
- 30% of individuals with acute stroke (excluding TIA) were discharged from acute care to inpatient rehabilitation.
- 28% of individuals post stroke (excluding TIA) were discharged from acute care and inpatient rehabilitation are referred to community/ambulatory rehabilitation.
- 49.2% of individuals with severe stroke were admitted to inpatient rehabilitation.

Community Stroke Rehabilitation Model

Consultations with stroke survivors, caregivers and service providers revealed a lack of service coordination and follow-up after discharge from acute care and inpatient rehabilitation as well as challenges identifying and accessing community services. *(Sources: Anderson, S & Egan M. (2010), Models of Care Coordination Report, Ontario Stroke Network. Kelloway, L (February 8, 2012), Briefing Note to Genevieve Obarski, Change Foundation, Ontario Stroke Network. MacRae, L & Gould L (November 2011), Preliminary Report: Stroke Care in the Central South Region, Central South Regional Stroke Network).*

To address these challenges, a Community Stroke Rehabilitation Model (CSRM) was launched in December 2013 (see details in Figure 9).

The goals of the CSRM were to improve access to evidence-based community outpatient stroke rehabilitation care and improve client outcomes post stroke event.

The Model provides access to best practice in-home community rehabilitative stroke care for individuals who live beyond 30 minutes of an outpatient therapy centre and/or do not have the tolerance to travel.

The in home CSRM Pilot targeted rehabilitation services for each client based on best practice. Prior to the launch of the CSRM model, individuals in Brant Haldimand Norfolk living more than 30 minutes from an outpatient therapy centre did not have access to best practice rehabilitative stroke care. Prior to the launch of the model, individuals received an average of 4.1 therapy visits, much less than recommended best practice. The CSRM Pilot provided therapy visits based on best practices of 2-3 visits per discipline for 8-12 weeks. An average number of 33.7 visits were provided per patient.

Timely access to rehabilitative care in the community was a key consideration in the CSRM pilot with a target of 3 days for the time to the first in home visit following discharge from inpatient hospital care. The CSRM was able to achieve a time to first contact of 2.1days, a time to first visit by a therapy service provider of 3.3 days and a mean time to first visit by a CCAC Care Coordinator of 4.1 days.

Table 1 – Time to First CCAC Care Coordinator Visit and Therapy Service Provider

	Target	Mean
Time to First Contact (Telephone or Therapy Visit)	3 days	2.1 days
Time to First Visit by Therapy Services Provider	3 days	3.3 days
Time to First CCAC Care Coordinator Visit	3 days	4.1 days

The 2014-15 results for 31 participants at their three month follow up indicated that the timely delivery of integrated rehabilitative care in the community resulted in improvements in patient outcomes. 90% of patients participating in the CSRM pilot met their goals, 90% received care from their consistent stroke team members 80% of the time and 87% of individuals were referred to a community program. Prior to the CSRM model patient outcome information in the community was not readily available. Following participation in the CSRM, improvements were noted in functional independence and reintegration to normal living post discharge from hospital regardless of the severity of stroke symptoms.

Figure 9 – Community Stroke Rehabilitation Model (CSRM) Outcomes

Community Stroke Rehabilitation Model (CSRM) Outcomes	
Reintegration to Normal Living Index (RNLI) scores from initial visit to discharge increased by:	❖ 9% for individuals with mild stroke ❖ 32% for individuals with moderate stroke ❖ 39% for individuals with severe stroke
Functional Independence Measure (FIM) scores from initial visit to discharge increased by:	❖ 5% for individuals with mild stroke ❖ 20% for individuals with moderate stroke ❖ 18% for individuals with severe stroke

Chronic Obstructive Pulmonary Disease

Chronic Obstructtive Pulmonary Disease (COPD) is a chronic, progressive respiratory condition that is often caused by smoking. Although the diagnosis of COPD is irreversible, symptoms and health outcomes can be improved and managed with treatment.

In 2013 (the most current data available), 5.9% of LHIN residents aged 35 years of age and older reported that they had been diagnosed with COPD which was higher than the provincial average of 4.3% *(Source; Canadian Community Health Survey 2013)*.

COPD continues to be a primary cause of emergency department visits, and admissions and readmissions to hospitals in the LHIN. In 2014, 5,387 individuals visited an ED within the LHIN for COPD, of those 2,976 were admitted. Approximately one in five individuals who are hospitalized with COPD are readmitted to hospital within 30 days and one in two are readmitted within one year.

The LHIN began work with hospitals and community partners in 2013-14 to implement a LHIN-wide integrated model of care for patients with COPD based on best practice and incorporated other related

initiatives. In February 2014, the *Caring for My COPD* program began accepting patients in Hamilton. Additional sites opened in Brantford in April 2014 and Niagara in May 2014.

The *Caring for My COPD* program provides a bundle of services to assist individuals with COPD and their health care team to increase the individual's medical stability and capacity for managing COPD at home and in the community. The ten-week intensive part of the program is provided to patients with mild to moderate COPD and includes education, exercise, assessments, mental health and wellness care, peer support and spiritual care and is monitored by monthly telephone calls for one year. These aspects are combined with case management by a Certified Respiratory Educator (CRE) trained coordinator in collaboration with the primary care provider to ensure individuals are able to stay healthy at home.

As of February 2015, 334 individuals were registered in the *Caring for My COPD* program. Introductory data suggests that the *Caring for My COPD* program is helping individuals remain healthy at home and in their communities without having to visit the hospital. Patient experience feedback from this program has been extremely positive, with many individuals returning to peer support groups and open exercise classes. A formal evaluation of this program began in January 2015 and is scheduled to be complete in 2016-17.

What Caring for My COPD clients told us

- "Have had three exacerbations without going to hospital since starting this program".
- "Went from 'worry' to 'relief'
- "I go out more in past three months vs last three years".
- "It has really helped me, it has changed my life".
- "I'm no longer scared to leave the house"
- "Invisible condition – good to have help with advocacy"
- "I just want to say thank you for the Caring for my COPD program, I honestly feel without it I would not be at the stage I am. I am losing weight, getting healthier every day, walking further every day."

(Source: COPD Presentation to HNHB LHIN Board – August 27, 2014, patients interviewed April – July 2014)

Palliative Care

In 2014-15, the HNHB LHIN established a competency-based Hospice Palliative Care Regional Council (Council) accountable to the LHIN's Chief Executive Officer (CEO). The Council's mandate is to:

- Act in an advisory capacity to the HNHB LHIN to recommend actions and activities to strengthen and develop a comprehensive integrated regional hospice palliative care program that is designed around the experience of patients, families and based upon a foundation of involved and supported primary care; and,
- Provide collaborative leadership to advance standardization, education, coordination and continuous quality improvement across all sectors within the HNHB LHIN based on best practices in accordance with the provincial Declaration Document - *Advancing High Quality, High Value Hospice Palliative Care: Declaration of Partnership and Commitment to Action in Ontario (Declaration) 2011.*

Since its inaugural meeting in July, 2014, the Council has installed a Director and finalized a comprehensive three-year (2015-2018) work plan that includes the development of three working groups:

- *The Early Identification Working Group* will identify test sites and recruit project team members for each site that will utilize and measure the benefits of using the Early Identification Guide.
- *The Regional Education Plan Working Group* will develop a coordinated education plan for all providers and sectors.
- *The Performance and Quality Measurement and Reporting Working Group* will report on new provincial indicators and develop regional indicators.

Palliative Care Shared Care Outreach Teams (PCSCOT)

As of December 2014, the team saw more than 2,383 patients, which exceeded the number seen in all of fiscal 2013-14. The Shared Care Outreach includes clinical navigators, clinical nurse specialists, psycho-spiritual counsellors, bereavement counsellors and palliative care physicians collaborating with providers across all settings.

In 2014-15 the LHIN Palliative Care Shared Care Outreach Team continued to evolve and provide services in Hamilton, Niagara, Haldimand Norfolk, Brant, Six Nations and Burlington which meet patient palliative care needs and enable individuals to receive the care they need within the comfort of their own home while supporting their caregivers.

Palliative Care Shared Care Outreach Teams – What the Clients told us

"I am so grateful for the outreach team. I would not have been able to do this without them, they provided care and answers when all other options were not available in the off hours. They found me a great doctor who has been a blessing. In the middle of the night when something goes south, it is beyond a relief to have someone - a real person, to call and get practical answers. Emergency is not a part of the palliative plan, so knowing who to call and getting the alternative directive was so vital. I cannot thank all of you enough."

– Cheryl Moore, Executive Director Stedman Hospice

Behavioural Supports Ontario (BSO) Project

The Behavioural Supports Ontario (BSO) Project is built on a framework that outlines principles to guide the development of quality health services for people with responsive behaviours. In 2012, the HNHB LHIN incorporated these principles and developed four models of care that redesign how services are provided to better meet the needs of this population.

In 2014-15 the LHIN's BSO activities continued to be driven by the statement identified by LHIN providers in 2012 that represents the voice of individual with responsive behaviours.

'I am who I am, so help me to continue to be me'

A focus in 2014-15 was to increase support for the person, family member and health care providers as they transitioned across the healthcare continuum.

Transitioning across the healthcare system can be a confusing and/or traumatic experience for an individual who due to cognitive impairment is at risk for responsive behaviours. The BSO Mobile Long-Term Care Mobile Team (BSO LTCH Team) provides support to the person, family and health service providers by getting to know the person and being present when they move to a new location. As of December 30, 2014 the BSO LTC Team supported total 491 transitions (Source HNHB BSO 2014-15 Q3 Report).

The LHIN's BSO models include:

- **BSO Connect** – A single point of information and referral for clients, caregivers, and healthcare providers active referrals, and pulling services towards clients operated by the HNHB Community Care Access Centre (CCAC).
- **BSO Community Outreach Team (COT)** – Five teams are located across the LHIN within existing community crisis teams providing 'just in time' (crisis) support to individuals with, or at risk of, developing responsive behaviours and linking them to longer term support.
- **Integrated Community Lead (ICL) Service Model** – One community agency is the single point of contact for BSO clients. This model is being adopted by LHIN-funded health service providers who provide care to the BSO population.
- **BSO Long-Term Care (LTC) Mobile Team** – Five teams have been implemented across the LHIN, serving the LHIN's 85 long-term care homes.

Key BSO 2014-15 successes

BSO Connect

- 1,347 clients served (2,550 since April 2012).
- 100% of caregivers/clients connected to service/support after calling BSO Connect.
- 64-70% of those clients received no services prior to calling BSO Connect (based on % range for five LHIN regions).

BSO Community Outreach Teams

- 1,200 clients received crisis support (3,000 since program implementation April 1 2012).
- 58% to 79% of clients discharged (% range for five regions in HNHB LHIN) with longer-term community supports in place to prevent future crisis (based on % range for five LHIN regions).

BSO LTC Mobile Team

- 2,654 clients served (5,810 since April 1, 2012), 894 clients were supported through transitions to LTC in 2014-15.
- Increased knowledge and utilization of transitional support offered by BSO LTC Mobile team for clients transitioning to/from LTC, resulting in well-planned moves from community or acute care to LTC for the resident, caregivers and staff. Transition referral numbers have increased from 3.44% of referrals in 2012-13 to 33.68% of referrals in 2014-15.
- Proactive work of supporting transitions to LTC resulting in a decreased re-admission rate to BSO program. One year pilot study revealed readmission rates to BSO program for residents provided with episodic support from BSO LTC team at 17.6%; however, readmission rates for residents provided with proactive transition support to LTC from BSO team was 4.8%.
- LTC Home staff report 85.7% of the time having a "clear plan in place for managing responsive behavior for the resident" after BSO LTC Mobile Team involvement.

Integrated Community Lead Model

Behavioural Supports Ontario – What the Clients told us

"I am more at ease…I made the right call to the right agency (BSO Connect) without having to make multiple calls"
– BSO CONNECTCaregiver

"The BSO (COT) service is better than good – it is very good! BSO provided to me, some very useful information to help me understand."
– Caregiver

"The BSO Team are very helpful with educating staff about reasons people act the way they do regarding responsive behaviours. They can take the extra time to investigate positive ways our team can help residents have the best quality of life possible." *– Kim, Registered Practical Nurse in Long Term* Care Home

- Implemented five ICL Community Partner Forums in Burlington, Brant, Haldimand-Norfolk, Hamilton and Niagara regions with over 200 front-line staff and managers in attendance. The forums were inter-organizational and provided education on the ICL approach to care to increase knowledge of and confidence in participating in the ICL practice. Additional goals of the forums included strengthening working relationships at frontline and organizational levels and strengthening clear communication among community partners when caring for BSO clients.

Other

- Implementation of a communication/referral tool in one emergency department to improve discharge planning and care coordination for the BSO population that present in ED.
- Creation of the Documentation of Responsive Behaviours in Hospitals Working Group to explore strengths and challenges experienced when providing accurate and contextual documentation regarding responsive behaviours in hospitals and the broader implications of documentation on quality of care and patient access and flow.
- The LTC Expert Panel Review began in September 2014. The purpose of this review was to analyze four high risk residents with responsive behaviours in LTC to identify alternate strategies to avoid unnecessary transfer to hospital. The panel has gathered to evaluate a summary of these cases and will meet again in May 2015 to resume the review of LTC and develop specific recommendations.

Collaborating with hospitals to understand the challenges associated with serving BSO clients was a key focus throughout many BSO initiatives in 2014-15 and will continue to be expanded upon in 2015-16.

eHealth

The Health Information Technology Services (HITS) eHealth Office manages the advancement of regional eHealth initiatives and priorities. The HITS eHealth Office, in concert with Hamilton Health Sciences (HHS), are leaders in the advancement of eHealth systems and solutions which enable improvements in health care delivery, patient care and safety.

The eHealth Office provides management services such as regional eHealth strategic planning, stakeholder engagement, communication, adoption, transformation and change management, proposal preparation and negotiation, program and implementation management and enhancement planning. As part of the Connecting South West Ontario (cSWO) Program, HHS and the HITS eHealth Office are the solution providers deploying ClinicalConnect™ across the Erie St. Clair, South West, Waterloo Wellington and HNHB LHINs, and are the regional delivery partners for HNHB.

The eHealth Office manages a number of initiatives with the view to improve patient care and safety, support provincial strategies like Health Links, and to better integrate data and services electronically across the continuum of care. A selection of those key projects are outlined below.

ClinicalConnect

ClinicalConnect is a secure web-based portal that provides physicians and clinicians with real-time access to their patients' electronic medical information from regional hospitals, Community Care Access Centres (CCACs) and Oncology Centres in South West Ontario. It also integrates data from eHealth Ontario's Ontario laboratories information system (OLIS), the Southwestern Ontario Diagnostic Imaging Network (SWODIN) and Canadian Health Outcomes for Better Information and Care (C-HOBIC) nursing assessments. ClinicalConnect is a fundamental tool in bridging the gap between disparate information systems spanning a wide geographical area and multiple regional healthcare facilities.

In the last year, a number of significant updates in terms of both data and functionality have been made to the portal. ClinicalConnect now aggregates data from 50 hospitals (up from 36 last year), four CCACs (up from two last year), OLIS, and eight hospitals' diagnostic images from SWODIN to complement the existing diagnostic reports available from most contributing organizations. By the end of summer 2015, it's expected that data from the remaining 18 hospitals in the Erie St. Clair and South West LHINs will be integrated as well. ClinicalConnect will provide an integrated Electronic Health Record (EHR) for the almost 4 million Ontarians living in the south west region of the province.

Thanks to aggressive change management and adoption efforts by cSWO Delivery Partners in the four South West Ontario LHINs, there are now more than 17,000 authorized users (up from 7,000 at this time last year). In addition, approximately 1,500 healthcare providers are able to access ClinicalConnect directly from their hospital information system through contextual launch capability, as opposed to logging into the website separately. On average, healthcare providers access more than 20 million personal health information data elements in real-time each quarter.

The benefits of ClinicalConnect are profound and are becoming widely-recognized by the user community. Workflow efficiency, safer and higher quality patient care, and improvements during transition of care are regularly cited as the areas of greatest benefit from both a patient and provider perspective.

Integrated Decision Support (IDS) Warehouse

IDS is a multi-LHIN Integrated Decision Support Business Intelligence Solution that provides for both system-wide and operational use to HSPs and LHIN offices. It consists of a live data repository, analytical tools and reporting services, and is fully operational in the HNHB, Toronto Central, South West and Waterloo Wellington LHINs.

In the pre-production environment, Mississauga Halton LHIN was completing testing and verification, with an anticipated go live of April 2015. Erie St. Clair LHIN's was expected to go live in later 2015 and negotiations with two other LHINs continue.

There are more than 850 active users in IDS system, which houses more 25 million patient unique encounter records linked by a master LHIN number, facilitating collaboration between sectors that are responsible for the patients' healthcare journey. From an eHealth perspective, IDS complements existing initiatives, such as the roll-out of ClinicalConnect, and can be used to help with predictive analytics and inform ecosystem development.

In 2014-2015 significant work was undertaken with the Association of Ontario Health Centres (AOHC) – the Community Health Centres' provincial reporting body, to implement an extract to IDS using data collected by Community Health Centres (CHCs). HNHB LHIN CHCs were early adopters of IDS and pilot testing with two CHCs' data has taken place. A June live timeframe for the two pilots is anticipated, opening the discussion with other LHIN CHCs to provide data to IDS and become part of the patient journey.

Diagnostic Imaging Repository

The past year has seen increased adoption and user satisfaction of the Diagnostic Imaging Repository (DI-r) following system updates and the integration of images with ClinicalConnect. In 2014 and during the first quarter of 2015, diagnostic images from eight hospitals were integrated with ClinicalConnect, in addition to those images already available from HHS facilities. Planning for the integration of images from the remaining South West Ontario hospitals is underway.

Repository staff continue to work directly with hospitals to increase adoption through ongoing engagement activities. Future projects related to the DI-r include the implementation of Foreign Exam Management across hospitals connected to the Repository, the rollout of the DI Service and Cost Optimization Project within the Waterloo Wellington and HNHB LHINs, as well as ongoing engagement activities at participating hospitals.

Diagnostic Imaging Common Service

The HITS eHealth team was finalizing the scope and plans for the prospective integration with eHealth Ontario's Diagnostic Imaging Common Service (DICS). This would enable access to new sources of DI reports including hospitals beyond the boundaries of South West Ontario and Independent Health Facilities (IHFs).

The integration of DICS into ClinicalConnect to support the sharing and viewing of DI reports is the first of two major milestones and will lay the foundation for a future enhancement to enable access to DI images when they become available. Timely and effective availability of diagnostic imaging results is important for medical decision making and can reduce unnecessary procedures.

Change Management & Adoption

Since last year, impressive strides have been taken to help health care providers adopt ClinicalConnect. The Transformation Team has targeted physicians and clinicians in the primary care, community and acute care sectors. Re-engagement campaigns were launched at West Haldimand General Hospital, Norfolk General Hospital, Joseph Brant Hospital, Niagara Health System and Hamilton Health Sciences.

A number of community health centres have signed ClinicalConnect Data Sharing Agreements and training is well underway for authorized staff at those centres. The same is true for a number of long-term care homes in the LHIN – some which are part of parent companies that have sites in other South West Ontario LHINs and our team has worked collaboratively with other cSWO Delivery Partners to ensure a smooth onboarding experience for these organizations. Engagement work continues with Public Health Units as well as Community Support Services and Mental Health & Addiction agencies in the LHIN.

Patient Flow

Patient flow continued to be a high priority for the HNHB LHIN in 2014-15 as LHIN hospitals collectively reported on a weekly basis (with a few exceptions) more than 500 people waiting in hospital to access an alternate level of care (ALC).

Patient flow was influenced in 2014-15 by a number of system pressures that influenced patients' transitions across the hospital system and the LHIN's ALC rate, notably:

- As of February 22, 2015, there were 554 individuals waiting in hospital for an alternate level of care (ALC) *(Source: ALCIS)*. This represented a 45% increase in the number of people waiting in hospital for an ALC since the LHINs lowest reported number of 382 in August 2012.
- An increase in the days reported for people waiting in all hospital bed types reached 44,322 days in November 2014 *(ALC SC March 2015 performance report);*
- In August 2014, 87 people had waited 100 days or more in hospital for an ALC *(ALC SC March 2015 performance report);*

- The number of people waiting in hospital for a long-term bed increased to 190 in April 2014 from a low of 126 in February 2013. (ALC SC March 2015 performance report);
- An increase in the number of new patients designated ALC monthly from 693 in January 2014 to 793 in January 2015, with a reported throughput ratio of 0.87. *(ALC SC March 2015 performance report).*

Providing timely access to the most appropriate level of care in the most appropriate place was required to improve patient flow and dramatically improve the person's experience with the health care system.

To achieve this, the LHIN in collaboration with the LHIN's Patient Flow Steering Committee (PFSC), HSPs and other key stakeholders explored opportunities within the hospital and community setting. Activities focused on:

- Interventions to prevent or reduce decline in a person's functional and cognitive status, especially for seniors;
- Development and implementation of standardized discharge policies and processes so the patient, family/caregiver and health care team are informed of the care plan in the hospital and at discharge;
- Increasing access to Transitional Care Programs in the community;
- Increase access to assisted living support in the community; and,
- Reduce the days individuals wait for access to long-term care and supervised or assisted living.

Patient Flow
Focuses on the transition of individuals across the health care system from the:
- Community to acute in-patient hospital care; and,
- Acute to post-acute care or home.

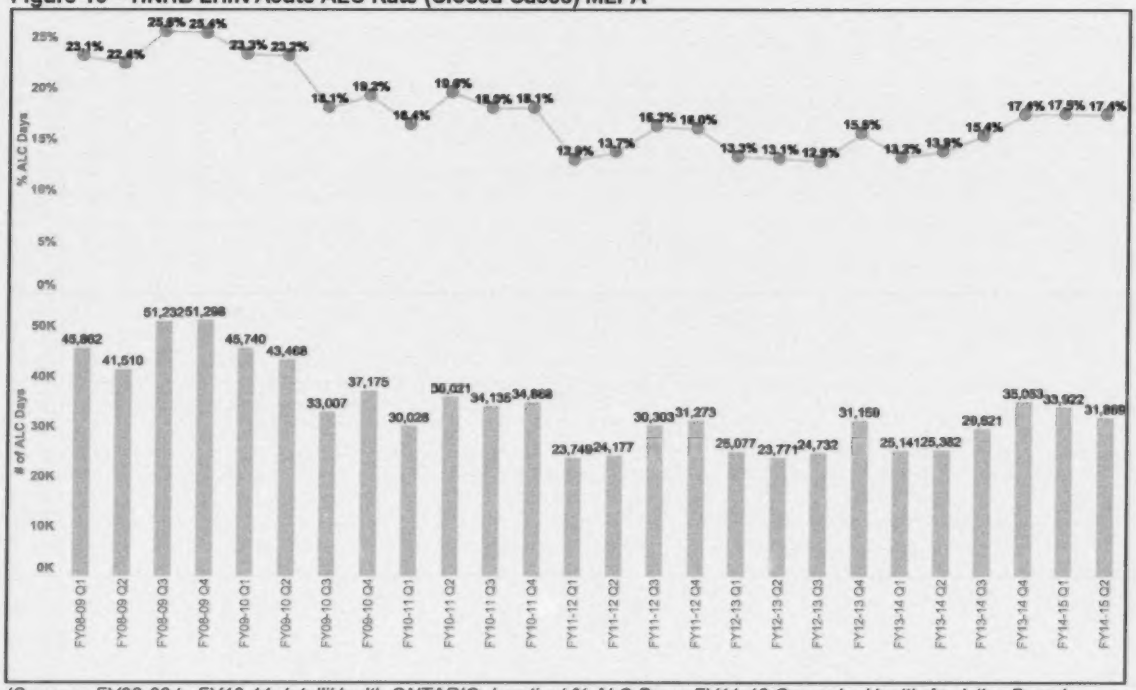
While it is not unexpected that situations will occur where individuals will experience a wait across the continuum, issues arise when individuals experience long waits in a hospital setting or when a large number of individuals wait in hospital for a post-acute care setting.

How Sluggish Patient Flow Impacts People
Person's Impact
- A person's recovery may be delayed or in the case of seniors may regress both physically and mentally while waiting for a more appropriate post-acute care setting
- Unnecessary long hospital stay exposes a person to a higher risk of hospital acquired complications

Peoples' Impact at the System Level
- Hospitals can become challenged to provide care of those who need it when a large number of people who no longer need acute hospital care are waiting in hospital for an alternate care setting. This can result in cancellation of elective surgery, long waits in the emergency departments or delays in receiving required services.

The LHIN monitors the number of days an individual waits in hospital for an ALC two ways:
- Closed cases – the total number of days that individuals have waited in hospital for an ALC by the time they were discharged
- Open cases the number of individuals that are still in hospital waiting for an ALC.

Figure 10 – HNHB LHIN Acute ALC Rate (Closed Cases) MLPA



(Sources: FY08-09 to FY10-11: IntelliHealth ONTARIO; Inpatient % ALC Days; FY11-12 Onwards: Health Analytics Branch MOHLTC; Supplementary MLPA Analysis (DAD))

Prevent, Reduce or Maintain Functional and Cognitive Status

Senior Friendly Hospitals

The Senior Friendly Hospital (SFH) strategy remains an important provincial priority and is an enabler to support several provincial strategies, including Health Links and the provincial Seniors' Care Strategy. The vision of SFHs is to enable seniors to maintain optimal health and function while they are hospitalized so that they can successfully transition home or to the next appropriate level of care *(Source: Senior Friendly Hospital Care Across Ontario. Summary Report and Recommendations, September 2011)*.

The LHIN-wide SFH Working Group reviews hospitals' successes and key challenges in implementing SFH improvement plans.

The SFH Working Group's priorities for 2014-15 were:

- Supporting Transitions in Care; and,
- Promoting Early Mobilization to Prevent Functional Decline.

An SFH environmental scan was conducted in Fall 2014 to identify improvements made in the SFH commitment and care since 2011. The improvements noted within the HNHB LHIN were:

- 89% of hospitals are involved in the screening, detection, prevention, management, monitoring and evaluation of delirium, compared to 50% in 2011;
- 100% of hospitals are involved in the screening, detection, prevention and management of functional decline, compared to 41% in 2011;

- 89% of hospitals have a process/structure in place for seniors sensitivity training, compared to 77% in 2011;
- 100% of hospitals have processes in place for advance care planning, compared to 45% in 2011;
- 100% of hospitals have processes for capacity and consent; and,
- 100% of hospitals have completed environmental upgrades.

(Source: Senior Friendly Hospital Care in the Hamilton Niagara Haldimand Brant Local Health Integration Network. Summary of Self-Assessment Responses, February 2015)

The SFH Advanced Leadership Training Program has been offered to all publicly-funded hospitals in Ontario for whom enhancing services to seniors is an important objective. The training program will build further capacity and continue the momentum of the provincial strategy through a training program informed by best practices in implementation science, quality improvement and change management.

Six LHIN hospitals have participated and completed the provincial functional decline and delirium indicator pilot. Preliminary evaluation results and recommendations will be included in the future work of the HNHB LHIN SFH Working Group for broader implementation.

Assess and Restore (AR) Approach – Prevention and Restorative Care

The HNHB LHIN has funded 124 restorative programs in seven locations across the LHIN to support people regain their optimal functional status following an acute illness. These programs are located in hospitals and long-term care homes and all provide restorative type care. People are usually admitted from the hospital following an acute event, but can be admitted directly from the community.

The AR health care team may include nurses, physiotherapists, occupational therapists, recreational therapists, pharmacists and case managers from the CCAC. People admitted to the program work with this healthcare team over a period of time to regain their strength to enable them to return home. April 1 through December 31, 2014 81% of the people admitted to the LHIN's Assess Restore and Slow Stream Restorative programs were discharged home. The LHIN also has 63 convalescent care beds located in three long-term care homes in Hamilton and Niagara.

In 2014-15 the LHIN implemented a seniors mobile assess restore team (SMART) model of care across five LHIN hospital sites. These teams will work with patients who are experiencing recent reversible functional decline and/or are at risk of further functional decline. SMART will be offered in emergency departments and acute medicines, with seven day timely access to the mobile assess restore team.

Healthy Active Seniors

Falls prevention among individuals over the age of 65 is a significant health concern in Canada. Individuals experiencing a fall often suffer from devastating physical and psychological injuries which negatively impact quality of life and activities of daily living. In a survey of providers from diverse senior-serving community organizations, 82% felt that falls were preventable and 75% agreed that older adults view falls as a top health concern. *(Source: Markle-Reid, M (2015). Engaging Community Organizations in Fall Prevention for Older Adults: Moving from Research to Action).*

Research has shown that progressive, tailored exercise programs contribute to improvements in strength, gait, and balance, as well as offer a chance for seniors to socialize and become more educated about key risk factors for falls. During the period of April 2014 to December 2014, the LHIN provided falls prevention exercise classes to 7,049 individuals across 187 locations throughout the region. The LHIN continues to work with community providers to maintain widespread access to LHIN-funded exercise programs and ensure that these programs continue to offer positive patient experiences with each class.

Keeping Active – What the clients told us

"I think this program is the best thing offered to seniors ever – it is physically great and very important from a social aspect!" – *Participant in Stay Strong Falls Prevention Program*

"I continue to find my balance improved when walking my dog! Often I am on uneven ground or come upon pine cones, rocks and other natural debris that once would have greatly imperiled me towards a fall. Now I am much more confident. The effect has also been very impressive in my husband who has Alzheimer's. He is more attentive and responsive, as well as walking better!" – *Participant in Stay Strong Falls Prevention Program*

Standardized Discharge Policies and Procedures

The LHIN continues to be a strong supporter of a Home First Philosophy. LHIN HSPs have approached Home First as a culture that focuses on discharging individuals home where appropriate following an acute hospital admission.

Home First is an evidence-based philosophy that focuses on transition management and supporting people to return home following a hospital stay. In July 2014 the HNHB Patient Flow Steering Committee (PFSC), recognized the need to standardize discharge practices and processes across LHIN providers to improve patient flow. The PFSC approved in principle the adoption of the Waterloo Wellington LHIN Standardized Discharge Process Policies and Procedures as a key component to a planned LHIN-wide Home First Refresh.

Key Objectives of the Standardized Discharge Processes and Procedures:

- Support patients to return home/access appropriate care prior to returning home, or moving to the next care destination;
- Improve communication and engagement with primary care providers;
- Greater consistency and collaboration of staff across organizations/sectors;
- Patients and families to be engaged early and often in the sharing of information about their care and development of supportive care plans; and
- Front-line and leadership working together to support patients access to care.

In 2014-15, all HNHB LHIN hospitals and CCAC were in the process of implementing the new *'HNHB Planning Your Care and Next Steps: Discharge and Transitions Toolkit'* during the LHIN-wide Home First Refresh. The development of this toolkit involved extensive engagement with multiple providers, primary care, patients and families and resulted in standardized discharge processes and procedures.

Transitional Bed Program

In early 2014, the LHIN seconded an individual from HHS to explore opportunities in Hamilton for a community-based transitional wellness program for seniors and other adults requiring 24 hour access to support and/or care. Since the submission of the final report in March 2014 titled, *"Hamilton Community Transitional Wellness Capacity Project"*, 102 transitional beds have been opened across the Hamilton and Burlington region.

The transitional bed programs are located in licensed retirement homes and assisted living environments where they provide access to appropriate care environments and services through a partnership with the CCAC. It is through these partnerships that individuals unable to return home following a hospital receive the right level of care while transitioning back to the community. Not only does this program provide a more appropriate care environment in the community, it improves overall patient flow by the shifting the capacity of acute care hospital resources to allow for more timely provision of acute care services.

Collaborative Home and Community Care

In 2014, the Ontario government implemented regulatory amendments to the *Home Care and Community Services Act, 1994* that allowed LHINs to fund designated Community Support Service (CSS) agencies to deliver in-home personal support services. Coinciding with this regulatory amendment were two policy guidelines, released by the ministry, which outlined terms by which a CSS agency would lead the care coordination of lower needs clients, and expand the mandate for select CSS agencies to provide in-home personal support services.

The LHIN, CCAC and LHIN-funded CSS agencies approved to provide assisted living services collaboratively developed an innovative service delivery model, which outlined the process for effectively operating as "one sector". This model facilitated a seamless and coordinated health care experience for older adults who are independent and whose care needs are relatively stable. The populations eligible for personal support services provided by a CSS agency had low to moderate care needs, were stable or moderately stable, did not require a large number or scope of services, and required few additional community supports.

In February 2015, the LHIN allocated $4,000,000 to support the implementation of this collaborative care model. This amounted to 127,795 hours annually of personal support services being coordinated by the designated CSS agencies that provided assisted living rather than the CCAC. This allowed the CCAC to accommodate the increasing number of individuals with higher levels of care needs.

Additionally, the LHIN was identified as an Early Adopter for implementing new policy guidelines related to the selected approval of new CSS agencies to provide in-home personal support services. As an Early Adopter, the LHIN contributed to the development of local strategies and goals, and continued to facilitate the local change process, informed provincial project principles and milestones, tested standards and definitions, and contributed to a toolkit for adoption by other LHIN partners in 2015-16.

The collaborative work of LHIN providers achieved improvements/successes towards improving patient flow:

- LHIN providers under the leadership of the HNHB LHIN PFSC and the Home First Refresh Committee developed and implemented the *"HNHB Planning Your Care and Next Steps: Discharge and Transitions Toolkit"*;
- Sustained reduction in the number of patients waiting in hospital for long-term care from 360 in August 2010 to 125 across all LHIN hospitals as of February 15 2015 *(Source: HNHB CCAC)*;
- As of February 2015, the number of people waiting 100 days or more for an ALC decreased to 65 from 87 reported in August 2015;
- Collaborated with Ministry of Community and Social Services on the successful discharge of persons experiencing long waits in hospital to access supervised supportive housing;
- Maintained ALC rate in complex care at 18-19%;
- Opened over 100 transitional care beds in the community; and,

- Continued to support patients needing higher levels of community support to return home from hospital, between April – December, 2014 2,666 individuals supported at home on service maximums *(Source: HNHB CCAC 2014-15 Third Quarter Report)*.

Emergency Department - Length of Stay

The Emergency Department (ED) length of stay (LOS) reflects the total amount of time individuals spend in the ED, from the time they register or are triaged (whichever occurs first) to the time when they leave the ED or are admitted to an inpatient hospital bed. During this time, the person sees the medical staff and receives care.

The LHIN monitors for three ED metrics that report the 90th percentile LOS for three population groups that present to the ED:

- Non-admitted population that is identified through the Canadian Triage Acuity Scale (CTAS) as 1-3 or 'High Acuity"
- Non-admitted population that is identified through the CTAS as 4 or 5 or 'Low Acuity"
- ED population that is admitted to an inpatient bed. Can be coded as CTAS 1-5

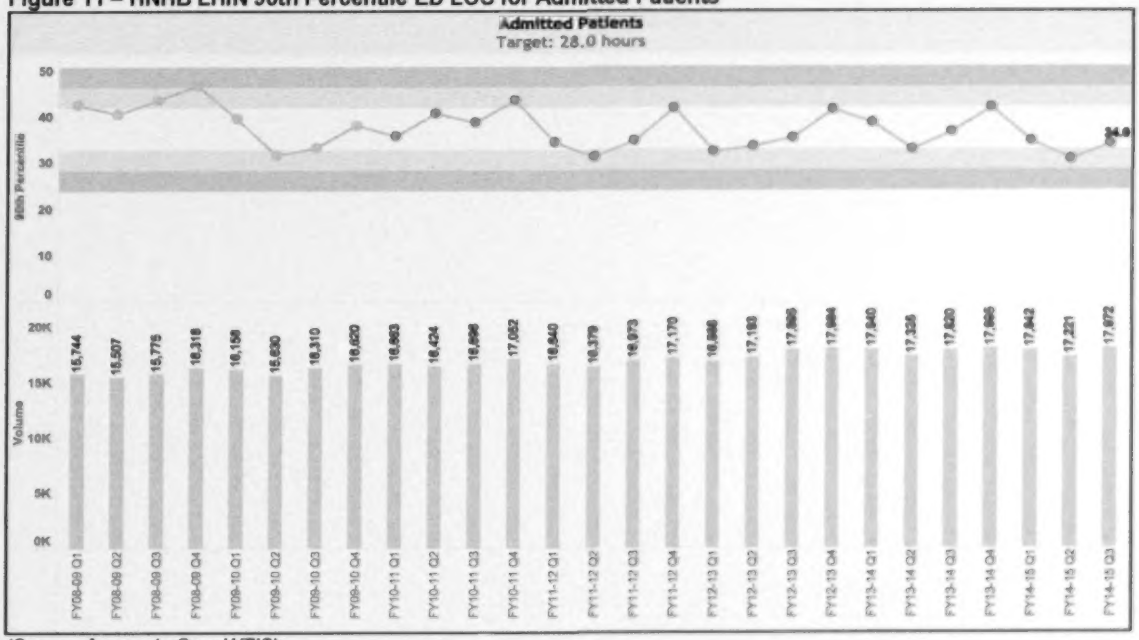
There are nine hospital corporations within the LHIN; these include two academic centres, three large community hospitals (one multi-site), one chronic care hospital and three small community hospitals serving rural areas. Eight of these hospitals provide emergency services across twelve sites, eight participate in the MOHLTC's Pay for Results initiative and one has a dedicated ED for children and youth.

How is ED LOS measured?
Hospitals report on the maximum amount of time in which 9 out of 10 patients completed their ER visit. The time the patient left the ER **minus** triage or registration time (whichever happens first) **equals** time spent in the ER (Source: MOHLTC).

The ED LOS for the Non-Admitted populations varied by ED site, the LHIN for the most part met or exceeded the LHIN's MLPA targets in 2014-15. (see Figure 12).

The LHIN has been most challenged to reduce the ED LOS for the admitted patient population especially during the winter months of January to March. The increase LOS reported by HNHB LHIN hospitals during the winter months is similar to the provincial pattern (see Figure 11).

Figure 11 – HNHB LHIN 90th Percentile ED LOS for Admitted Patients



(Source: Access to Care WTIS)

Factors Contributing to ED LOS

There are a variety of health system pressures that have made decreases in ED LOS challenging, especially for the admitted ED population.

ED Volumes

HNHB LHIN hospitals are experiencing an increase in the number of people presenting to the ED. From 2013-14 fiscal year to 2014-15 fiscal year ED visits increased by 18,067, with the highest growth in the non-admitted High Acuity population. The percent change in ED volumes reported by HNHB LHIN hospitals exceeded the province in all populations except the admitted population (Refer to Figure 12).

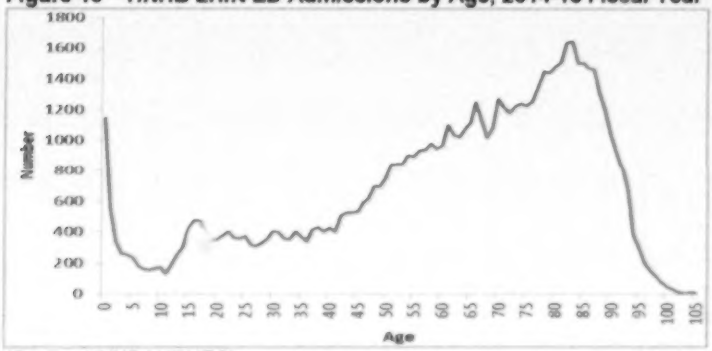
Figure 12 – HNHB LHIN ED Volumes 2013-14 Fiscal Year compared to 2014-15 Fiscal Year

ED Population	HNHB LHIN Absolute Change	HNHB LHIN Relative Change	Province
Total ED Population	**18,067**	**3.4%**	**2.6%**
Non-Admitted High Acuity	**17,774**	**5.6%**	**5.4%**
Non-Admitted Low Acuity	**-180**	**-0.1%**	**-1.7%**
Admitted	**120**	**0.2%**	**2.1%**

(Source: Access to Care WTIS)

The portion of the population demonstrating the greatest increase was aged 75 years and older representing 37% of admissions.

Figure 13 – HNHB LHIN ED Admissions by Age, 2014-15 Fiscal Year



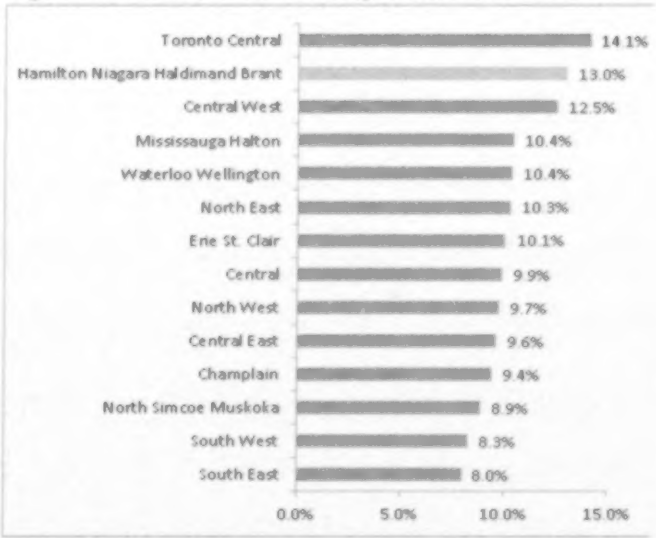
(Source: HNHB LHIN IDS)

Admission Rates

A key factor for the ED LOS for the admitted patient population is the number of unplanned ED admissions against the number of available beds. If a hospital has a large number of people waiting in a hospital for an ALC combined with a large number of unplanned ED admissions patient flow becomes an issue.

The HNHB LHIN reports the second highest admission rate of all LHIN's at 13%. Comparing LHIN hospitals to their peers, seven of the LHIN's 11 adult ED sites rank within the top three sites for the highest admission rates.

Figure 14 – ED Admission Rates by LHIN, 2014-15 fiscal Year



(Source: Access to Care- ER Informatics, Cancer Care Ontario)

Key Activities to Reduce ED Demand and ED LOS

Pay for Results

Eight ED sites across five hospital corporations participated in the MOHLTC's Pay for Results (P4R) program. Based on the previous years' performance on five specific indicators, hospitals receive one-time funding to implement patient flow strategies which focus on further reducing the time people spend in the emergency department. These initiatives included Rapid Assessment Zones for low acuity patients, Patient Flow Coordinators, enhancing ED support services, additional Triage Nursing time, and additional ED Physician hours.

P4R participating HNHB LHIN hospitals:

- Brant Community Healthcare System
- Hamilton Health Sciences
  - Hamilton General Hospital
  - Juravinski Hospital and Cancer Centre
  - McMaster Children's Hospital
- Joseph Brant Hospital
- Niagara Health System
  - St. Catharines Site
  - Niagara Falls Site
- St. Joseph's Healthcare Hamilton

Screening Tool for High Risk Seniors

The LHIN, hospitals and the CCAC worked together to implement an evidence-based screening tool to identify seniors who may be at high risk of needing community supports. Individuals aged 75 and older are screened in HNHB Emergency Departments in order to identify those at high risk. Individuals identified as being at risk are referred to the CCAC to be assessed for services or, depending on services needed, connected to the appropriate community supports. Each month, more and more patients are connected with community services such as personal support, occupational therapy, adult day programs, meals-on-wheels, and volunteer visiting. Patients who are already on service with the CCAC and were screened as high risk through this tool were connected back to their Care Coordinator to have their care plan reviewed and adjusted if needed.

From April 2014 to March 31, 2015 3,506 individuals were screened and identified as high risk. Of these

- 1,499 patients already received CCAC services and their care plans were adjusted as necessary,
- 2,007 were not known to CCAC and were all contacted to determine if they had service needs ,
- 813 patients were determined eligible and offered services through the CCAC with 525 being admitted to CCAC, 268 clients/families declined service; and,
- 969 patients were not eligible for CCAC services.

Emergency Services Steering Committee

The Emergency Services Steering Committee (ESSC) provides leadership to LHIN health service providers and the LHIN organization in the planning and implementation of initiatives to improve service quality and wait times for emergency services across the LHIN.

In 2014-15, a number of projects were funded to improve the patient experience:

- HHS – Hamilton General Hospital – funding was awarded to trial the creation of a 'virtual discharge team' to help increase patient flow.
- HHSC – McMaster Children's Hospital – funding was awarded to create a pediatric mental health emergency follow-up clinic.
- McMaster University – Geriatric Education and Research in Aging Sciences (GERAS) Centre – funding was awarded to evaluate opportunities to avoid transferring Long-Term Care Home residents to hospitals for IV therapy.
- Niagara Emergency Medical Services (EMS) received additional funding to continue to work on the OMEGA project, which is a strategy for improving utilization of emergency department resources by finding alternative medical pathways for non-urgent patient groups.

In addition the ESSC created a Quality Enhancement fund to promote quality initiatives in HNHB Emergency Departments. $40,000 has been budgeted annually for activities related to quality. This is to support small quality assurance projects or research activities by providing seed funding to supplement expenses that may be incurred. The ESSC also created a budget for educational activities targeting ED staff – the ED Directors' Committee is leading the creation of these opportunities.

ED Critical Link

This program started on April 2, 2013 and involved the partnering of small/medium sized emergency departments with large community emergency departments for the ongoing care of "semi-critical" patients that do not meet the requirements of a life or limb policy or regional program acceptance policy. While this program is unique to the LHIN, it is being considered in other parts of the province.

The model includes the following:

- Direct ED physician to physician discussion, consultation and possible referral to determine management plan and disposition; and,
- CritiCall is involved in all ED to ED discussions to assist in physician to physician contact and to ensure that an appropriate resolution is determined.

During 2014-15, the Critical Link Program was activated for 15 patients; ten required transfer to another ED site, three required transfers to other hospitals and two were able to be treated at the original site after consultation with the ED physician at the partner site. Those patients received the most appropriate care in the most appropriate place.

While these numbers are lower than the previous year, this was likely due to the implementation of the Life or Limb policy.

Life or Limb Policy

The Life or Limb policy ensures that people who suffer from a situation that endangers their life or a limb will receive immediate care in the hospital that can care for them. This provincial policy was activated in January 2014. This allows hospitals to quickly connect with larger community or Regional referral centers for advice and transportation of critically ill patients for require more intensive critical care. HNHB LHIN has had 121 patients transferred using the Life or Limb guidelines.

The Life or Limb policy has the following guiding principles:

- The Provincial Life or Limb Policy is in effect when a patient is life or limb threatened and therapeutic options exist, which are needed within four hours;
- A patient's life or limb threatening condition is a priority and the identification of beds is a secondary consideration and patients with this condition are not refused care;
- LHIN geographic boundaries do not limit a patient's access to appropriate care in another LHIN; and,
- Repatriation within a best effort window of 48 hours once a patient is deemed medically stable and suitable for transfer is critical to ensuring ongoing access for patients with life or limb threatening conditions.

MLPA Performance Indicators

Performance Indicator	LHIN 2014/15 Starting Point	LHIN 2014/15 Performance Target	Most Recent Quarter 2014/15	FY 2014/15 LHIN Result
Access to Healthcare Services				
1. 90th percentile ER length of stay for admitted patients	35.63	28.00	40.47	34.67
• In 2014-15, the HNHB LHIN was most challenged to sustain a reduced emergency room (ER) length of stay (LOS) for the admitted patient population. Six out of the LHIN's twelve emergency rooms reported annual 90th percentile LOS higher than the MLPA target of 28 hours. • Factors contributing to the higher LOS included an increase in the number of patients admitted to the hospital through the ER, higher acuity of patients admitted, and an increasing trend in the number of individuals waiting in hospital for an alternate level of care. Also, in December 2014 an Influenza A breakout impacted patient flow across the continuum. • Four LHIN ER sites (Joseph Brant Hospital and Niagara Health System – St.Catharines, Welland and Niagara General) that account for 36% of the LHINs ER admitted population, continued to experience challenges in achieving improvements for this metric reporting LOSs from 30.7 hours to 65.3 hours. • A series of key activities were undertaken to assist hospital organizations to reduce the ER LOS. These activities included a new and expanded transitional Assisted Living program, bed mapping at the Hamilton General site to increase capacity to meet demand, and the continued work of a Process Improvement Facilitator at Niagara Health System to improve ER performance metrics and patient flow. • The HNHB LHIN was completing a review of the population presenting with "failure to cope" at St.Joseph's Hamilton Healthcare as well as further analysis of the ER admitted population across the HNHB LHIN.				
2. 90th percentile ER length of stay for non-admitted complex (CTAS I-III) patients	7.80	7.50	7.30	7.30
• In 2014-15 the HNHB LHIN met the MLPA target for this metric. HNHB LHIN hospitals' initiatives targeting this metric included: comprehensive reviews of patient flow in the ER, refinement of staffing models to meet ER volume demand, and focused efforts to serve the low-acuity patients. • Five of the LHIN's 12 ER sites reported LOS higher than the LHIN target ranging from 7.8 hours to 8.7 hours. This metric is influenced by increased number of patients waiting in the ER to be admitted to the hospital and increase in the number of individuals triaged as high acuity (CTAS 1, 2, 3).				
3. 90th percentile ER length of stay for non-admitted minor uncomplicated (CTAS IV-V) patients	4.87	4.50	4.65	4.50
• In 2014-15 the HNHB LHIN met the MLPA target for this metric. During September, October and December this target reported slightly above (12 minutes) the MLPA target of 4.5 hours due to various outbreaks, respiratory illnesses in the Fall and Influenza-like illnesses in December. • Nine of the LHIN's 12 ER sites reported LOS higher than the LHIN target reporting LOS ranging from 4.7 to 6.4 hours. • Hospitals'continued to target this metric through work on the following initiatives: structured information				

sharing between sites for coaching purposes; updating and expanding medical directives to help expedite tests and treatments for low acuity patients; and expansion of community Paramedicine initiatives.				
4. Percent of priority IV cases completed within access target (84 days) for cancer surgery	85.00%	90.00%	84.68%	86.89%
• Over the past year, we have continued to work with our various hospital sites to improve OR efficiencies and work with individual surgeons on their coding practices. • The Regional Oncology Steering Committee regularly reviews quarterly performance targets and shares learnings, best practice, and opportunities across the HNHB LHIN. • Over the past year, we have seen increases in new cases of breast, gastrointestinal, prostate, gynecological, and head and neck cancers compared to 2013-14. • Newly recruited surgeons (colorectal, gynaecology, hepatobiliary) are beginning to improve our surgical wait times. • We continue to see longer wait times for prostate surgery, as the demand for the Robotic Prostate Procedure continues to impact wait times and we do not forsee any immediate improvement in this Robotic wait time. • The Cancer Clinical Services Plan continues to improve the regional organization of Surgical Oncology by disease and satellite cancer services for system therapy are now operating across the HNHB LHIN.				
5. Percent of priority IV cases completed within access target (90 days) for cardiac by-pass surgery	97.80%	90.00%	100.00%	100.00%
• The HNHB exceeded the MLPA target for this metric. The LHIN closely monitors factors that could impact wait times for cardiac surgery such as hospital patient flow pressures.				
6. Percent of priority IV cases completed within access target (182 days) for cataract surgery	87.00%	90.00%	85.13%	85.39%
• The HNHB LHIN was challenged to meet the MLPA target for this metric in 2014-15. • Hospital providers and data continue to support that demand for this service has exceeded the supply of surgeries available through the Quality-Based Procedure (QBP) allocation to the HNHB LHIN. This has negatively impacted wait times for our residents, and attempts to clear the backlog of cases continue. A LHIN-wide focus on prioritizing surgery for patients who were past the 182 day target occurred this year, with those patients who had waited the longest, receiving their surgery first. • Three of the five HNHB facilities that perform cataract surgery achieved the target in FY2014-15. • The LHIN-Wide Ophthalmology Steering Committee has worked to implement the LHIN-Wide clinical services plan, available on the LHIN website, to facilitate improvements in standardized care and access to ophthalmic services within the LHIN. Performance data and strategic initiatives to target LHIN-wide improvements in performance are reviewed monthly with the Steering Committee members. • The LHIN has continued to work with all hospital providers to develop a LHIN-Wide focused utilization of data to facilitate wait-list management. Data has included analysis of use of Dates Affecting Readiness to Treat (DARTs), two day business rule compliance levels for opening and closing surgical cases, long wait case analysis and transparent sharing of physician wait lists for cataract surgery at hospitals to facilitate referrals to the shortest surgical wait when possible.				
7. Percent of priority IV cases completed within access target (182 days) for hip	77.00%	85.00%	82.59%	81.91%

replacement				
• The HNHB LHIN improved in performance towards meeting this target in 2014-15. • Factors contributing towards delayed access include: primary care referral patterns, patient preference for specific site and/or surgeon, a backlog of patients waiting for surgery and ongoing demand which limits the ability to clear backlog. • Guided by the Integrated Orthopedic Capacity Plan, initiatives have been put in place to reduce variation in wait times and ensure quality of care. The HNHB LHIN Orthopedic Leadership Committee has worked to standardized physician order sets, patient care pathways, and patient education material across all hospitals in the LHIN. • A Wait List Management Policy has been developed to enable standardized wait list management and accurate data reporting, as well as promote surgeon participation in the Regional Joint Assessment Program; this will promote improved access to surgery to ensure patients are offered and provided the first available surgical date. • Performance is reviewed with hospitals at minimum on a monthly basis and more frequently as specific issues are noted.				
8. Percent of priority IV cases completed within access target (182 days) for knee replacement	64.00%	80.00%	74.63%	76.44%
• The HNHB LHIN improved in performance towards meeting this target in 2014-15. • Factors contributing towards delayed access include: primary care referral patterns, patient preference for specific site and/or surgeon, a backlog of patients waiting for surgery and ongoing demand which limits the ability to clear backlog. • Guided by the Integrated Orthopedic Capacity Plan, initiatives have been put in place to reduce variation in wait times and ensure quality of care. The HNHB LHIN Orthopedic Leadership Committee has worked to standardized physician order sets, patient care pathways, and patient education material across all hospitals in the LHIN. • A Wait List Management Policy has been developed to enable standardized wait list management and accurate data reporting, as well as promote surgeon participation in the Regional Joint Assessment Program; this will promote improved access to surgery to ensure patients are offered and provided the first available surgical date. • Performance is reviewed with hospitals at minimum on a monthly basis and more frequently as specific issues are noted.				
9. Percent of priority IV cases completed within access target (28 days) for MRI scans	45.00%	60.00%	57.58%	45.96%
• A LHIN-wide education session for family physicians was completed in November, 2014 in conjunction with Choosing Wisely Canada and the Ontario Medical Association as well as Radiologists and Surgical Specialists within the HNHB LHIN, to enhance the appropriateness of Magnetic Resonance Imaging (MRI) and CT scan ordering. An ultimate goal of reducing unnecessary risks of imaging for patients was targeted with this education session. • The LHIN did not meet the annual target for this metric in 2014-15, although monthly performance in February and March did meet the target. • Challenges meeting the demand for Priority 3 cases (more urgent) were noted and hospital providers worked to meet both Priority 3 and Priority 4 patient needs to the greatest degrees				

possible by adjusting booking templates.

- Information was shared with primary care providers identifying all LHIN hospital wait times for MRI and encouraging referrals to facilities with the shortest wait times.
- Through a joint Diagnostic Imaging and Orthopedic working group, recommendations for plain x-ray films as opposed to MRI/CT use were shared with family physicians to reduce unnecessary demand for MRI/CT.

10. Percent of priority IV cases completed within access target (28 days) for CT scans	68.00%	82.00%	69.00%	77.09%

- A LHIN-wide education session for family physicians was completed in November, 2014 in conjunction with Choosing Wisely Canada, the Ontario Medical Association, as well as Radiologists and Surgical Specialists within the HNHB LHIN, to enhance the appropriateness of CT scan ordering. An ultimate goal of reducing unnecessary risks of imaging for patients was targeted with this education session.
- Challenges meeting the demand for Priority 3 cases (more urgent) were noted and hospital providers worked to meet both Priority 3 and Priority 4 patient needs to the greatest degrees possible by adjusting booking templates and working collaboratively across hospital sites.
- Information was shared with primary care providers identifying all LHIN hospital wait times for MRI and encouraging referrals to facilities with the shortest wait times.
- Through a joint Diagnostic Imaging and Orthopedic working group, recommendations for plain x-ray films as opposed to MRI/CT use were shared with family physicians to reduce unnecessary demand for MRI/CT.

Integration and Coordination of Care

11. Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	13.89%	12.00%	18.25%	17.62%

- In 2014-15, the HNHB LHIN did not meet the MLPA target for this metric. Patient flow and the number of patients waiting in hospital for an Alternate Level of Care (ALC) continue to be a priority for the HNHB LHIN. The LHIN has a very active Patient Flow Steering Committee that meets monthly to review standardized metrics and develop strategies aimed at improving patient flow and achieving the MLPA target.
- In 2014-15, LHIN hospitals experienced an increasing trend in the number of individuals waiting in hospital for an ALC. From February to December 2014, the volume of open ALC cases in acute hospital beds in the HNHB LHIN increased from 596 to 735 (Source: WTIS). Patient flow pressures continue throughout the HNHB LHIN however are especially noted at the Hamilton hospitals accounting for just over 72% of this increase. Improvements have been noted for this metric and the volume has decreased from 391 reported in September to 349 in December 2014; however, the HNHB LHIN remains having the highest volume in comparison to other LHINs.
- The HNHB LHIN has also reported the highest volume of discharged ALC cases across the province, discharging 696 ALC cases in December 2014 (Source: WTIS).
- In 2014-15, the HNHB LHIN approved the following funding to support patient flow:
  - $984,528 to support 91 transitional Assisted Living beds opened across the HNHB LHIN.
  - $8.5 million in new recurring one time funding to support increased home services.
  - $1 million to a collaborative home and community support model.
  - $260,142 to support two Behavioural Supports Ontario Clinical Leads who will work with LHIN

hospitals to address barriers to discharge individuals with a history of responsive behaviours experience.

- The LHIN continued to work with HSPs to improve patient flow and performance. CCAC is actively working with Retirement Homes in all LHIN zones to look for opportunities for congregate settings where individuals could be supported while awaiting LTCH placement. Additional partnerships and opportunities continue to be explored to better connect patients with structured supports as they transition transition to community settings.
- Targeted strategies to address patient flow challenges included: continuing to work with a Process Improvement Facilitator (Black Belt) with the Niagara Health System (as noted under ER); implementation of a LHIN-wide Home First Refresh; implementation of a Home and Community Support model, transitioning low and moderate stable acuity clients from CCAC to LHIN Assisted Living provider, allowing CCAC to focus on complex clients; and, value stream mapping the Home with CCAC ALC designation at HHS and BCHS.

12. 90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	26.00	26.00	21.00	23.00

- In 2014-15, the HNHB LHIN met the MLPA target for this metric. Only one service type, Personal Support Worker and Homemaking, reported a wait time above the provincial average. The HNHB LHIN continues to work with CCAC and Community Support Service agencies to ensure timely access to services in the home.
- In February 2015, a new collaborative service model between the CCAC and CSS agencies was implemented. This innovative service model is in alignment with the ministry policy guideline for collaborative home and community-based care coordination, and is intended to enhance the capacity of CSS agencies to support individuals who have low to moderate care needs, are stable and relatively independent, and require few additional community supports. By effectively operating as "one sector", this collaborative model allows the CCAC to focus on clients with complex and post-acute needs.

Quality and Improved Health Outcomes

13. Readmission within 30 Days for Selected CMGs**	16.40%	15.40%	16.33%	16.44%

- In 2014-15, the HNHB LHIN did not meet its MLPA target for this metric. COPD and CHF continue to be the two clinical cohorts impacting performance for this metric with readmission rates of 20% and 22.4%, respectively.
- In Q4 13-14, the HNHB LHIN was 0.7% above the target rate of readmission within 30 days for selected CMGs of 15.4%. The HNHB LHIN currently ranks 6th in the province for this metric.
- The HNHB LHIN continues to work on key initiatives targeting this metric which include: Discharge Transition Bundle (DTB) teach back materials for COPD and CHF, Health Links coordinated care plans for identified patients with complex care needs, four community-based COPD clinics, and strategies identified in the LHIN Diabetes Work Plan.

14. Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	18.40%	17.00%	18.03%	18.84%

- In 2014 -15 the HNHB LHIN did not meet the MLPA target for this metric. During the most recent part of the year, however, there was some improvement for this indicator.
- The HNHB LHIN has had recent community investment funding that includes expanded Mobile Crisis

Rapid Response Teams in three zones across the LHIN, and specialized training to enhance clinical skills for health care professionals to support individuals with complex mental health needs who are high users of emergency services.				
15. Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	23.90%	22.70%	27.93%	26.64%
• While there were periods of improvement throughout the year, overall the HNHB LHIN did not meet the MLPA target for this metric for 2014-15. • The HNHB LHIN continues to work on and identify key initiatives to target this metric with a focus on patterns of substance abuse among the high needs population that access ER services. This includes early identification and referral for treatment of substance use.				

*FY 2014/15 is based on most recent four quarters of data (Q4 2013/14 - Q3 2014/15) due to availability
**FY 2014/15 is based on most recent four quarters of data (Q3 2013/14 - Q2 2014/15) due to availability

Financial Statements and Notes

Financial statements of

Hamilton Niagara Haldimand Brant Local Health Integration Network

March 31, 2015

Hamilton Niagara Haldimand Brant Local Health Integration Network

March 31, 2015

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Independent Auditor's Report

To the Members of the Board of Directors of the
Hamilton Niagara Haldimand Brant
Local Health Integration Network

We have audited the accompanying financial statements of Hamilton Niagara Haldimand Brant Local Health Integration Network, which comprise the statements of financial position as at March 31, 2015, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Hamilton Niagara Haldimand Brant Local Health Integration Network, as at March 31, 2015 and the results of its operations, change in its net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
May 27, 2015

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of financial position
as at March 31, 2015

	2015	2014
	$	$
Financial assets		
Cash	868,913	756,953
HST receivable	25,366	32,205
Accounts receivable - other	180	942
Due from Ministry of Health and Long-Term Care ("MOHLTC") transfer payments to Health Service Providers ("HSPs") (Note 9)	22,453,844	49,450,245
	23,348,303	50,240,345
Liabilities		
Accounts payable and accrued liabilities	213,956	367,510
Due to the MOHLTC (Note 3b)	725,631	428,415
Due to Health Service Providers ("HSPs") (Note 9)	22,453,844	49,450,245
Due to the LHIN Shared Services Office (Note 4)	81	2,107
Deferred capital contributions (Note 5)	43,958	69,170
	23,437,470	50,317,447
Commitments (Note 6)		
Net debt	(89,167)	(77,102)
Non-financial assets		
Prepaid expenses	45,209	7,932
Tangible capital assets (Note 7)	43,958	69,170
Accumulated surplus	-	-

Approved by the Board

_____ Director

_____ Director

The accompanying notes to the financial statements are an integral part of these financial statements.

Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of operations
year ended March 31, 2015

	Budget (Note 8)	2015 Actual	2014 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSPs transfer payments (Note 9)	2,826,311,100	2,895,775,446	2,836,986,207
Operations of LHIN	4,916,172	4,897,490	4,855,909
Project Initiatives			
Enabling Technologies for Integration Project Mangement Office ("ETI PMO") (Note 4)	510,000	510,000	580,000
ER/ALC Performance Lead	-	100,000	100,000
French Language Services	-	106,000	76,266
French Language Planning Entity	-	411,693	411,693
Emergency Dept LHIN LEAD	-	75,000	75,000
Critical Care LHIN LEAD	-	75,000	75,000
Aboriginal Planning	37,500	37,500	37,500
Primary Care LHIN Lead	-	75,000	75,000
Diabetes Education	-	841,301	841,301
Physiotherapy	-	-	27,344
Amortization of deferred capital contributions (Note 5)	-	43,893	40,181
	2,831,774,772	2,902,948,323	2,844,181,401
Funding repayable to the MOHLTC (Note 3a)	-	(725,631)	(428,415)
	2,831,774,772	2,902,222,692	2,843,752,986
Expenses			
Transfer payments to HSPs (Note 9)	2,826,311,100	2,895,775,446	2,836,986,207
General and administrative (Note 11)	4,916,172	4,228,189	4,469,987
Project Initiatives (Note 10)			
ETI PMO	510,000	510,000	580,000
ER/ALC Performance Lead	-	100,000	100,000
French Language Services	-	106,000	76,266
French Language Planning Entity	-	411,693	411,693
Emergency Dept LHIN LEAD	-	73,478	75,000
Critical Care LHIN LEAD	-	72,599	72,688
Aboriginal Planning	37,500	37,500	37,500
Primary Care LHIN Lead	-	75,000	75,000
Diabetes Education	-	832,787	841,301
Physiotherapy	-	-	27,344
	2,831,774,772	2,902,222,692	2,843,752,986
Annual surplus and closing accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of these financial statements.

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Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of change in net debt
year ended March 31, 2015

	Budget (Note 8)	2015 Actual	2014 Actual
	$	$	$
Annual surplus	-	-	-
Change in prepaid expenses	-	(37,277)	27,080
Acquisition of tangible capital assets	-	(18,681)	(90,263)
Amortization of tangible capital assets	-	43,893	40,181
Increase in net debt	-	(12,065)	(23,002)
Net debt, beginning of year	-	(77,102)	(54,100)
Net debt, end of year	-	(89,167)	(77,102)

The accompanying notes to the financial statements are an integral part of these financial statements.

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Hamilton Niagara Haldimand Brant Local Health Integration Network

Statement of cash flows
year ended March 31, 2015

	2015	2014
	$	$
Operating transactions		
Annual surplus	-	-
Add items not affecting cash		
Amortization of capital assets	43,893	40,181
Less items not affecting cash		
Amortization of deferred capital contributions	(43,893)	(40,181)
Changes in non-cash operating items		
Accounts receivable - other	762	15,685
HST receivable	6,839	(11,279)
Due from MOHLTC to HSPs	26,996,401	(37,514,245)
Accounts payable and accrued liabilities	(153,554)	143,742
Due to the MOHLTC	297,216	67,024
HSPs from MOHLTC	(26,996,401)	37,514,245
LHIN Shared Services Office	(2,026)	(7,089)
Prepaid expenses	(37,277)	27,080
	111,960	235,163
Capital investment		
Acquisition of tangible capital assets	(18,681)	(90,623)
Financing transaction		
Capital contributions received	18,681	90,263
Net change in cash	111,960	235,163
Cash, beginning of year	756,953	521,790
Cash, end of year	868,913	756,953

The accompanying notes to the financial statements are an integral part of these financial statements.

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Hamilton Niagara Haldimand Brant Local Health Integration Network

Notes to the financial statements

March 31, 2015

1. **Description of business**

The Hamilton Niagara Haldimand Brant Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Hamilton Niagara Haldimand Brant Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Counties of Hamilton, Niagara, Haldimand, Brant, most of the County of Norfolk and the City of Burlington. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry - LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC"). These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Service Providers ("HSPs"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed HSPs in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2015.

The LHIN has also entered into an Accountability Agreement with the MOHLTC, which provides the framework for LHIN accountabilities and activities.

The LHIN statements do not include any MOHTLC managed programs.

2. **Significant accounting policies**

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian Public Sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment, furniture and fixtures	5 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year. Infrastructure/web development costs are included with computer equipment for accounting and reporting purposes.

Segment disclosures

The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of operations and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

2. **Significant accounting policies (continued)**

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimate and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

3. **Funding repayable to the MOHLTC**

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Funding received	Eligible expenses	2015 Excess funding	2014 Excess funding
	$	$	$	$
Transfer payments to HSPs	2,895,775,446	2,895,775,446	-	-
LHIN operations	4,941,383	4,228,189	713,194	426,103
ETI PMO	510,000	510,000	-	-
French Language Planning Entity	411,693	411,693	-	-
French Language Services	106,000	106,000	-	-
ER/ALC Performance Lead	100,000	100,000	-	-
Emergency Dept. LHIN LEAD	75,000	73,478	1,522	-
Critical Care LHIN LEAD	75,000	72,599	2,401	2,312
Primary Care Lead	75,000	75,000	-	-
Aboriginal Planning	37,500	37,500	-	-
Diabetes Education	841,301	832,787	8,514	-
	2,902,948,323	2,902,222,692	725,631	428,415

b) The amount due to the MOHLTC at March 31, 2015 is made up as follows:

	2015	2014
	$	$
Due to MOHLTC, beginning of year	428,215	361,391
Prior year BSO funds not spent	-	-
Funding repayable related to current year activities to the MOHLTC (Note 3a)	725,631	428,215
Amount recovered by the MOHLTC during the year	(428,215)	(361,391)
Due to MOHLTC, end of year	725,631	428,215

4. Related party transactions

LHIN Shared Services Office, Local Health Integration Network Collaborative

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at the year end, are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared services agreement the LSSO has with all LHINs.

Enabling Technologies for Integration Project Management Office

Effective January 31, 2014, the LHIN entered into an agreement with South West, Erie St. Clair and Waterloo Wellington LHIN's (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies for Integration Project Management Offices for its Cluster and related expenses. During the year, the LHIN received funding from the South West LHIN of $510,000.

5. Deferred capital contributions

	2015	2014
	$	$
Balance, beginning of year	69,170	19,088
Capital contributions received during the year	18,681	90,263
Amortization for the year	(43,893)	(40,181)
Balance, end of year	43,958	69,170

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due under existing leases are as follows:

	$
2016	172,786
2017	172,786
2018	172,786
2019	71,994

The LHIN also has funding commitments to HSPs associated with accountability agreements. The actual amounts which will ultimately be paid are contingent upon LHIN funding received from MOHLTC.

7. Tangible capital assets

	Cost	Accumulated amortization	2015 Net book value	2014 Net book value
	$	$	$	$
Office, equipment, furniture and fixtures	482,062	473,563	8,499	3,221
Computer equipment	245,223	209,764	35,459	65,949
Leasehold improvements	572,444	572,444	-	-
	1,299,729	1,255,771	43,958	69,170

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of operations reflect the initial budget at April 1, 2013. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $2,895,775,446 is derived as follows:

	$
Initial budget	2,826,311,100
Adjustment due to announcements made during the year	69,464,346
Final budget	2,895,775,446

The final LHIN general and administrative budget of $7,147,666 is derived as follows:

	$
Initial budget	
LHIN operations	4,916,172
ETI PMO	510,000
Aboriginal Planning	37,500
Additional funding received during the year for:	
French Language Planning Entity	411,693
French Language Services Coordinator	106,000
ER\ALC Performance Lead	100,000
Emergency Dept. LHIN LEAD	75,000
Critical Care LHIN LEAD	75,000
Primary Care Lead	75,000
Diabetes Education	841,301
Final budget	7,147,666

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $2,895,775,446 (2014 - $2,836,986,207) to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2015 as follows:

	2015	2014
	$	$
Operations of hospitals	1,914,168,474	1,892,233,026
Grants to compensate for municipal taxation - public hospitals	464,700	464,025
Long-term care homes	478,905,154	460,634,986
Community care access centres	307,373,115	302,761,326
Community support services	47,447,841	45,063,756
Acquired brain injury	7,619,608	6,987,746
Assisted living services in supportive housing	34,857,366	30,250,506
Community health centres	28,958,381	25,416,149
Community mental health addictions program	75,980,807	73,174,687
	2,895,775,446	2,836,986,207

The LHIN receives money from the MOHLTC which it in turn allocates to the HSPs. As of March 31, 2015 an amount of $22,453,844 (2014 - $49,450,245) was payable to the HSPs. This amount has been reflected as revenue and expenses within the LHIN's operations and is included above.

10. Project initiatives

The LHIN received funds for various project initiatives listed in the Statement of Operations. The following table classifies the initiatives expenses by object:

	2015	2014
	$	$
Salaries and benefits	894,626	986,210
Professional services	1,201,529	1,170,613
Shared services	41,000	51,000
Occupancy	38,687	30,391
Supplies	13,079	21,032
Mail, courier and telecommunications	18,194	28,992
Other	11,942	8,554
	2,219,057	2,296,792

Diabetes strategy operational expenses included in the project initiative expenses above are as follows:

	Actual 2015	Actual 2014
	$	$
Salaries and benefits	717,701	700,109
Others	115,086	171,192
	832,787	871,301

11. Expenses by object

The Statement of operations presents the expenses by function. The following classifies general and administrative expenses by object:

	2015	2014
	$	$
Salaries and benefits	3,107,790	3,258,641
Board Chair per diems	19,425	29,621
Directors' per diems	24,396	30,875
Board expenses	7,913	10,393
Travel	19,268	26,087
Consulting services	78,279	168,140
Community forums and communication	40,281	46,092
Supplies, equipment, maintenance, other	55,801	88,645
Occupancy costs	319,080	244,752
Amortization	43,893	40,181
Shared services	512,063	526,559
	4,228,189	4,469,986

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of 40 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2015 was $282,948 (2014 - $289,995) for current service costs and is included as an expense in the Statement of operations. The last actuarial valuation was completed for the plan as at December 31, 2014. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act*, 2006 and in accordance with s. 28 of the *Financial Administration Act*.

Board Members

(as of March 31, 2015)

Michael P. Shea
Chair

Ruby Jacobs
Vice Chair

Helen Mulligan
Board Member

Laurie Ryan-Hill
Board Member

Mervin Witter
Board Member

Senior Staff Member

Donna Cripps
Chief Executive Officer

On behalf of the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network, we are pleased to submit this Annual Report for the period ended March 31, 2015.

Michael P. Shea
Chair, Board of Directors

Ruby Jacobs
Vice Chair, Board of Directors

Hamilton Niagara Haldimand Brant **LHIN**

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